

**ABORIGINAL NURSING STUDENTS' EXPERIENCES
IN TWO CANADIAN SCHOOLS OF NURSING:
A CRITICAL ETHNOGRAPHY**

by

DONNA ELIZABETH MARTIN

B.N., The University of Manitoba, 1991
M.N., The University of Manitoba, 1997

**THESIS SUBMITTED IN PARTIAL FULFILMENT OF
THE REQUIREMENTS FOR THE DEGREE OF**

DOCTOR OF PHILOSOPHY

in

THE FACULTY OF GRADUATE STUDIES

(Nursing)

THE UNIVERSITY OF BRITISH COLUMBIA

June 2006

© Donna Elizabeth Martin, 2006

ABSTRACT

Motivated by a projected shortage of Aboriginal nurses and recurring difficulties in recruitment and retention of Aboriginal peoples in schools of nursing, a critical ethnography was conducted to examine the construction of undergraduate Aboriginal nursing students' (ANS) experiences in two Canadian schools of nursing. The study was guided by tenets from several theoretical and methodological perspectives: Aboriginal epistemology, decolonizing methodologies for research and Indigenous peoples, cultural safety, and the social organization of knowledge.

Data sources included semi-structured interviews with ANS (n=31), Aboriginal nurses (n=5), faculty (n=24), and key informants (n=16) who volunteered to participate. Other data sources were reflexive and descriptive field notes from 200 hours of fieldwork in classroom and laboratory practice sessions. As well, pertinent texts were randomly selected and analyzed. These texts (n=135) included recruitment brochures, nursing textbooks, journal articles, course syllabi, schools' policies and procedures, and websites to further explicate how nursing discourse shaped ANS' experiences.

Although ANS described long and arduous journeys to and through the schools of nursing, their major concern was inadequate funding from Band sponsorship, Canada Student Loans or other sources. ANS' stressors were strongly influenced and magnified by the intersectionality of gender, race, culture, economic status, and geographical distance from social supports. ANS' stories illustrated how they used personal agency to ultimately realize their dream of becoming a highly independent and contributing member of society.

Different explanatory models about nursing knowledge, practice and environments created tensions between ANS and teachers and sustained the hegemony within the institution rather than empower the student. Key informants identified how colonization and the history of Aboriginal education and nursing education in Canada continued to shape a disconnection in the student-teacher relationship as experienced by both ANS and nurse educators.

Although health care needs of Aboriginal peoples are paramount in Canada, nursing curricula lacked the inclusion of information related to promotion of Aboriginal health. In the rare situation where Aboriginal health was addressed, dismal epidemiological statistics were listed and negative stereotypical portrayals were sustained. Curriculum content about historical influences of colonialism and neo-colonialism shaping Aboriginal health and information about diversity with the Aboriginal culture were absent. Based upon these findings, recommendations were made to enhance the educational experiences of ANS in Canadian schools of nursing.

Key words: Aboriginal education, critical ethnography, recruitment, retention

TABLE OF CONTENTS

Abstract	ii
Table of Contents	iv
List of Tables	x
Acknowledgments	xi
Dedication	xiv
1 Introduction and Background to the Thesis	1
1.1 Introduction.....	1
1.2 Purposes of the study.....	4
1.2.1 Research purposes.....	4
1.2.1.1 Research questions.....	4
1.2.2 Practical purposes.....	5
1.2.3 Personal purposes.....	5
1.3 The need for a critical ethnography.....	7
1.4 Organization of the thesis.....	9
1.5 Chapter summary.....	11
2 Review of Existing Knowledge	12
2.1 Introduction.....	12
2.2 Historical overviews.....	14
2.2.1 Brief history of Aboriginal education.....	15
2.2.1.1 Traditional education: prior to European contact.....	15
2.2.1.2 Colonial domination and segregation.....	16
2.2.1.3 Assimilation.....	19
2.2.1.4 Self-determination.....	22
2.2.2 History of Aboriginal Peoples in Canadian nursing.....	24
2.3 The social construction of existing knowledge.....	27
2.3.1 Struggles.....	28
2.3.1.1 Inadequate primary and secondary education.....	28
2.3.1.2 Lack of support services.....	30
2.3.1.3 Rigid institutional policies and procedures.....	33
2.3.1.4 Ethnocentrism.....	34
2.3.1.5 Inadequate funding.....	38
2.3.2 Survival.....	41
2.3.2.1 Previous life experience.....	42
2.3.2.2 Perseverance.....	42

TABLE OF CONTENTS (Continued)

2.3.2.3	Interpersonal support.....	43
2.3.2.4	Playing the game.....	43
2.3.2.5	Desire to make life better.....	44
2.3.3	What was missing?.....	44
2.3.3.1	Intergroup relations.....	45
2.3.3.2	Racism.....	47
2.3.3.3	Inclusive and anti-racist teaching strategies.....	48
2.4	Chapter summary.....	50
3	Theoretical and Methodological Perspectives.....	52
3.1	Introduction.....	52
3.2	Aboriginal epistemology.....	56
3.3	Decolonizing methodologies for research and Indigenous peoples.....	60
3.4	Cultural safety.....	63
3.5	The social organization of knowledge.....	67
3.5.1	Social organization.....	70
3.5.2	Social relations.....	70
3.5.3	Ruling relations.....	71
3.5.4	Texts.....	71
3.5.5	Experience.....	72
3.6	Chapter summary.....	73
4	Method of Inquiry.....	75
4.1	Introduction.....	75
4.2	Critical ethnography/Institutional ethnography.....	76
4.2.1	Sampling.....	79
4.2.1.1	Research settings.....	79
4.2.1.2	Gaining and sustaining access.....	81
4.2.1.2.1	Advisory council.....	81
4.2.1.2.2	Research setting.....	82
4.2.1.2.3	Aboriginal nursing students.....	84
4.2.1.2.4	Nursing faculty.....	88
4.2.1.2.5	Key informants.....	88
4.2.1.3	Description of the sample.....	90
4.2.1.3.1	Overview of Aboriginal students and nurses.....	92
4.2.1.3.2	Nursing faculty.....	96
4.2.1.3.3	Key informants.....	96
4.2.1.3.4	Texts.....	97
4.2.2	Relationship between researcher and researched.....	98
4.2.3	Data collection.....	103
4.2.3.1	Interviews with Aboriginal nursing students and nurses.....	104

TABLE OF CONTENTS (Continued)

4.2.3.2 Interviews with faculty members.....	108
4.2.3.3 Interviews with key informants.....	110
4.2.3.4 Field notes.....	110
4.2.3.5 Texts.....	112
4.2.4 Data analysis.....	113
4.2.4.1 Ensuring scientific quality.....	117
4.2.4.1.1 Triangulation.....	118
4.2.4.1.2 Construct validity.....	119
4.2.4.1.3 Face validity.....	119
4.2.4.1.4 Catalytic validity.....	120
4.3 Ethical considerations.....	120
4.4 Chapter summary.....	124
5 Becoming a Nurse: The Standpoint of Aboriginal Nursing Students.....	125
5.1 Introduction.....	125
5.2 Becoming a nurse: A long and arduous journey.....	127
5.2.1 Journey to the school of nursing.....	127
5.2.1.1 A dream to become a nurse.....	127
5.2.1.2 Making a better future.....	129
5.2.1.3 Alternate pathways.....	131
5.2.1.4 Substandard education on reserves.....	131
5.2.1.5 Transition and/or access programs.....	133
5.2.2 Journey through the school of nursing.....	134
5.2.2.1 Culture shock.....	136
5.2.2.1.1 Adjustment to urban lifestyle.....	136
5.2.2.1.2 Adjustment to urban campus.....	137
5.2.2.2 Informal and formal supports.....	137
5.2.2.2.1 Personal agency.....	138
5.2.2.2.2 Social support.....	142
5.2.2.2.3 Access programs.....	143
5.2.2.2.4 Academic resources.....	144
5.2.2.3 Intersectionality.....	145
5.2.2.3.1 Personal issues.....	145
5.2.2.3.2 Lack of social support.....	146
5.2.2.3.3 Lack of childcare.....	147
5.2.2.3.4 Ethnocentrism.....	149
5.2.2.3.5 Racism.....	155
5.2.2.3.6 Conflicts with teachers.....	160
5.2.2.3.7 Inadequate funding.....	162
5.2.2.4 Journey's end.....	167
5.3 Chapter summary.....	169

TABLE OF CONTENTS (Continued)

6 Teaching Aboriginal Nursing Students: The Standpoint of Nursing Faculty.....	172
6.1 Introduction.....	172
6.2 Local context.....	174
6.2.1 Profile of participating faculty.....	174
6.2.2 Limited experience teaching Aboriginal students.....	175
6.2.3 Perceptions of Aboriginal students.....	179
6.2.3.1 Complex personal lives.....	179
6.2.3.2 Students' personal agency.....	181
6.2.4 Perceived inequalities.....	182
6.2.4.1 More funding.....	183
6.2.4.2 More academic assistance.....	186
6.2.4.3 More resources.....	187
6.2.4.4 Skepticism about academic standards.....	188
6.2.4.5 Differences in academic preparation	189
6.3 Translocal context: Where ANS and faculty meet.....	191
6.3.1 Student-teacher relationship.....	191
6.3.1.1 Disconnectedness.....	191
6.3.1.2 Culture clashes.....	193
6.3.2 Connectedness.....	196
6.3.3 Pedagogy.....	197
6.3.3.1 Philosophies of teaching and learning.....	199
6.3.3.1.1 Outcome-oriented teaching.....	199
6.3.3.1.2 Process-oriented teaching.....	200
6.3.3.1.3 Consequences of outcome-oriented teaching.....	202
6.3.4 Curriculum.....	207
6.3.4.1 Portrayal of Aboriginal Peoples.....	210
6.3.5 Classroom size.....	212
6.3.6 Documents, policies and procedures.....	214
6.3.6.1 Syllabi.....	214
6.3.6.2 Performance improvement plans.....	215
6.3.6.3 Clinical evaluation forms.....	216
6.3.6.4 Passing a course.....	217
6.3.6.5 Leave of absences.....	217
6.3.6.6 Permanent departure.....	219
6.4 The extra local context: Outside the school.....	220
6.4.1 Standards of practice.....	220
6.4.2 Nursing shortage.....	221
6.4.3 Band influences.....	221
6.4.4 Expectations of Aboriginal community.....	222
6.5 Chapter summary.....	222

TABLE OF CONTENTS (Continued)

7 Key Informants' Views about Aboriginal Nursing Students' Experiences	226
7.1 Introduction	226
7.2 Broader historical context	227
7.3 Perceptions of Aboriginal nursing students	229
7.3.1 Critical thinkers	229
7.3.2 Cognitive dissonance	230
7.4 An uneven playing field	232
7.4.1 Entrance requirements	232
7.4.2 Perceptions of nursing faculty	234
7.4.3 Student-teacher relationships	236
7.4.4 Curriculum and pedagogy	237
7.4.4.1 Clinical courses	240
7.4.4.1.1 One-sided "snap shot" clinical evaluations	242
7.4.5 No mentorship programs	244
7.5 External factors	246
7.5.1 Demands from home communities	246
7.5.1.1 Pull towards families	247
7.5.1.2 Responsibilities to the Band	248
7.5.1.3 Returning to Aboriginal communities	249
7.5.2 Nursing education and population health	250
7.5.3 Portrayal of Aboriginal peoples	251
7.5.3.1 Government	252
7.5.3.2 Canadian media	252
7.6 Chapter summary	253
8 How Nursing Discourse Shaped Aboriginal Nursing Students' Experiences	255
8.1 Introduction	255
8.2 Overview of reviewed texts	255
8.2.1 Recruitment brochures	257
8.2.2 Course syllabi	257
8.2.3 Required readings	262
8.2.4 Textbooks	263
8.2.5 Websites	264
8.3 Linking discourse to experience	265
8.3.1 Relationships between Aboriginal students and faculty	266
8.3.2 The construction of a "good" nurse	274
8.3.3 Absent and/or exclusionary discourse	276
8.3.4 Diversity with Aboriginal nursing students' experiences	280
8.3.5 Hegemony	282
8.4 Chapter summary	283

TABLE OF CONTENTS (Continued)

9 Summary and Discussion.....	285
9.1 Introduction.....	285
9.2 Thesis summary.....	286
9.3 Discussion.....	290
9.3.1 Aboriginal epistemology.....	291
9.3.2 Decolonizing methodologies.....	292
9.3.3 Cultural safety.....	293
9.3.4 Social organization of knowledge.....	294
9.3.5 Study's contributions to new knowledge.....	295
9.3.5.1 Intersectionality.....	295
9.3.5.2 Racism exists.....	298
9.3.5.3 Equality and fairness versus equity.....	299
9.3.5.4 Differing explanatory models.....	300
9.3.5.5 Personal agency.....	301
9.4 Recommendations.....	302
9.4.1 Professional nursing associations.....	302
9.4.2 Educational administrators.....	302
9.4.3 Educators and researchers.....	304
9.4.4 Aboriginal organizations.....	306
9.5 Conclusion.....	306
 References.....	 308
 Appendices.....	 325
Appendix A.....	324
Appendix B.....	329
Appendix C.....	330
Appendix D.....	331
Appendix E.....	333
Appendix F.....	334
Appendix G.....	336
Appendix H.....	340

List of Tables

Table 1 Commonalities and unique features of theoretical and methodological perspectives.....	55
Table 2 Profiles of participants.....	95
Table 3 Profile of texts reviewed.....	256

ACKNOWLEDGEMENTS

I would like to acknowledge the Aboriginal nursing students and Aboriginal nurses who volunteered to share their experiences in a school of nursing. I was humbled and honored to hear their stories depicting vision and perseverance. I would like to express my gratitude to the Aboriginal nurses who advised and encouraged me during the research process. Many thanks to Lucy Barney, Marie Jebb, Gertie Merasty, Indigo Sweetwater and Dr. Evelyn Voyageur for their time, effort, advice and guidance. Also, I wish to thank Ms. Ardelle Kipling, RN, BN, for her ability to facilitate a connection with ANS, analyzing several transcripts, and participating in the dissemination of study findings.

I would like to acknowledge the inspiration of Dr. Barbara Paterson as the original chair of my thesis committee. Dr. Paterson provided me with guidance and encouragement to pursue a project studying the educational experiences of Aboriginal nursing students. By mentoring me and assisting me in writing many grant applications, I received guidance in formulating a research design, affirmation of the importance of this study that enhanced confidence and skills as a nurse researcher and scientist.

When Dr. Paterson relocated to another university, I was fortunate that Dr. Joan Anderson agreed to assume the position of chair. I am particularly grateful for witnessing Dr. Anderson's strength and ease at conceptualizing complex social interactions and the social relations identified in this study. Dr. Anderson worked alongside Ms. Kipling and me to assist us throughout the phases of data analysis. As Dr. Paterson and Dr. Anderson were experienced in the method of inquiry, I was privy to

acquire advice and guidance from expert researchers, scholars, and in particular, skilled and talented nurse educators. I viewed Drs. Paterson and Anderson as positive role models in that they demonstrated incredible patience and support for me throughout the study.

I acknowledge the encouragement and feedback from Dr. Carol Jillings. With her knowledge and expertise in educational administration, curriculum development, and instructional design, I acquired further insight into the construction of Aboriginal nursing students' experiences. Dr. Jillings was an exemplary role model for me in her establishment of a healthy balance between home and work. With Dr. Jillings on my committee, I was encouraged to stay grounded in attending to life's priorities.

Dr. Michael Marker provided me with guidance during an independent study where I initially reviewed the literature about Aboriginal peoples' experiences in postsecondary education. Dr. Marker encouraged me to examine existing knowledge for what was present and what was missing. Dr. Marker graciously introduced me to his expertise in the area of white-Indian relations and Linda Smith's work - decolonizing methodologies for research and Indigenous peoples (1999).

Taking the liberty of speaking on behalf of the rest of the committee members, we all had the pleasure of working with Dr. Michael Marker who encouraged me to stay "true" to my data despite its sensitive nature and the forthcoming challenges of dissemination of findings and knowledge translation. Dr. Marker stimulated many provocative discussions about social relations at committee meetings.

The study was funded by a doctoral fellowship from the Social Sciences and Humanities Research Council and by a doctoral trainee award from the Michael Smith Foundation for Health Research.

I would like to thank all my family members, especially Kim Orris, my husband for supporting and encouraging me to pursue my dreams. I realize that attending to the doctoral research meant that sometimes, I was absent physically, mentally, and emotionally. Finally, I would like to thank my parents who somehow instilled in me that learning was a valuable lifelong process.

***In loving memory of Beth Martin, my mother who told me that
the knowledge isn't from you – it comes through you***

1 INTRODUCTION AND BACKGROUND TO THE THESIS

"I don't think anyone is brave enough to write on this, otherwise, we would be penalized for stating the truth" (Anonymous Aboriginal nurse, 2001).

1.1 Introduction

Despite a growing Aboriginal population in Canada, recruitment and retention of Aboriginal¹ peoples² continues to be problematic in Canadian schools of nursing. The percentage of Aboriginal peoples in some Western provinces currently approaches 13.6%, while the overall percentage of Aboriginal peoples in Canada was 3% in 1996. In an ideal world, the student nurse population mix would reflect the overall population mix of the region. Nurse educators must ensure that nurses – the largest group of health care providers – reflect Canada's rapidly changing demographics and have the experience, research expertise, and professional socialization to address the critical health care issues facing Aboriginal peoples (Griffiths & Tagliareni, 1999). "A priority, then, for nursing is the need to prepare nurses who are qualified to address biophysical and psychosocial issues germane to a growing minority population" (Griffiths & Tagliareni, 1999, p. 291).

Unfortunately, the percentage of Aboriginal peoples in nursing education remained less than 1% in 2002 with only eight Aboriginal individuals enrolled in

¹ I use the term, Aboriginal, to refer to Indigenous peoples of Canada. Aboriginal peoples include First Nations People, Status and Non-Status Indians, Métis, and Inuit as reflected in the current historical, social, cultural and political context (Health Canada, 2002). Indigenous peoples in North America refer to themselves as Indian, Native, First Nations, and Aboriginal when they are talking about Indigenous peoples in a general fashion. You will see a variety of these terms used in quotations throughout the dissertation.

² "Peoples" is intentionally plural to reflect the right of self-determination and to acknowledge the great diversity among Aboriginal individuals, families, and communities in the vast geographical span of Canada (Castellano, 2000; L. Smith, 1999). Although it is more accurate and respectful to use the name of each tribe such as Lakota, Plains Cree, or Salish, I refer to participants as Aboriginal to protect their identities.

graduate nursing education (0.4%). Of approximately 35,730 undergraduate and diploma nursing students in Canada in 2002, there were approximately 240 Aboriginal nursing students (ANS) – a mere 0.7% of the total undergraduate nursing student population (Canadian Nurses Association & Canadian Association of Schools of Nursing, 2004; Health Canada, 2002). A study by Health Canada proclaimed that 800 new Aboriginal nurses were needed for the near future (Aboriginal Nurses Association of Canada, 2004b). The supply of 240 ANS will not meet the demand for 800 Aboriginal nurses. Therefore, actions were urgently required to improve recruitment and retention of Aboriginal peoples in nursing education (Aboriginal Nurses Association of Canada, 2005).

Furthermore, some administrators and researchers identified that Aboriginal communities received more appropriate health care when Aboriginal nurses were the care providers (Hart-Wasekeesikaw, 1999; Indian and Northern Affairs Canada, 2004; Keitner, 1999; Martin, 1997; Martin & Gregory, 1996; Weaver, 1999). In contrast to Euro-Canadian or Non-Aboriginal nurses, Aboriginal nurses were more likely to:

- understand and speak the language of the community,
- be knowledgeable about the health beliefs of the community,
- integrate Traditional healing with Western Medicine, and
- participate in community development (Martin, 1997).

Currently, the supply of Aboriginal nurses is not meeting the demand. Aboriginal communities are experiencing the worst nursing shortage in 30 years with a nurse vacancy rate of 40% (Aboriginal Nurses Association of Canada, 2002b; MacLeod, Kulig, Stewart, & Pitblado, 2004; "Natives face," 2001). Given the dire need for Aboriginal

nurses to work in Aboriginal communities and the lack of ANS, Canada's Aboriginal communities may experience an even bleaker nursing shortage (Aboriginal Nurses Association of Canada, 2004b).

Additionally, Aboriginal and non-Aboriginal nurses voiced concerns about the educational experiences of ANS (Aboriginal Nurses Association of Canada, 2002a, 2002b, 2004a, 2004b; Health Canada, 2002; Martin, 1997; Walsch, 1995; Weaver, 2001; Womack, 1997; Yurkovich, 1997). In light of this concern and a projected worsening of the nursing shortage, health care administrators announced an urgent need to improve recruitment and retention of Aboriginal peoples in nursing education (Indian and Northern Affairs Canada, 2004).

Health Canada and First Nations and Inuit Health Branch (FNIHB) are committed to increasing the presence and participation of Aboriginal registered nurses within their respective organizations. Aboriginal communities, the Aboriginal Nurses Association of Canada, and the "Royal Commission of Aboriginal People" (1996) have also expressed the need for more nurses of Aboriginal ancestry (Health Canada, 2002, p. 5).

To improve recruitment and retention of Aboriginal peoples in nursing, nurse educators and educational administrators required more information about factors that enhanced or hampered the educational experiences of ANS. A study that examined how ANS experience their nursing education and how contextual factors shape or influence their experiences was warranted.

1.2 Purposes of the study

Maxwell (1998) identified three types of purposes for a study: research, practical, and personal. Using Maxwell's framework (1998), I outline my story of why I studied ANS' experiences.

1.2.1 Research purposes

Research purposes are focused on developing knowledge (Maxwell, 1998). By answering the research questions, this dissertation will contribute to the development of nursing knowledge. I designated three main purposes of the dissertation: (a) describe the experiences of ANS – the local³, (b) explicate tensions between social groups within a school of nursing – the translocal⁴, (c) and illuminate hidden or embedded messages within the texts and discourse of nursing education that influence the social relations – the extra local⁵.

1.2.1.1 Research questions

Stemming from these purposes, I formulated five relevant research questions.

These questions were:

1. What are some of the everyday/every night experiences of ANS in Canadian schools of nursing?
2. What are the similarities/differences between the experiences of ANS who originated from an urban versus a northern community?

³ The term, local, is synonymous with the everyday/everynight world of ANS (D. Smith, 1987). The local setting is the starting point for explicating how activities within the school of nursing are shaped by 'outside influences' (Grahame & Grahame, 2000/2001; D. Smith, 1987). As poignantly stated by Geertz (1983), critical ethnography is a craft of place; it works "by the light of local knowledge" (p. 167).

⁴ The term, translocal, reflects the social relations between ANS and other groups occurring within the school of nursing (D. Smith, 1990). Translocal refers to the processes of administration and governance that serve to organize and control the local or the everyday world (DeVault & McCoy, 2001).

⁵ The phrase, extra local, refers to operations occurring beyond the local and translocal but work alongside the translocal to function as forms of ruling (D. Smith, 1999).

3. How are the experiences of ANS determined?
4. What are the social relations that generate the experience of ANS?
5. What are the ways in which the sociocultural, political, historical, and ideological construction of nursing education shapes ANS' experiences?

1.2.2 Practical purposes

By grasping a better understanding of ANS' experiences and building supports and diminishing barriers, nurse educators will enhance ANS' educational experiences and increase recruitment and retention of ANS in Canadian schools of nursing. Based on the recommendations of this study, nursing education administrators can develop policies and implement recruitment and retention strategies to graduate a number of Aboriginal nurses that more closely matches the service needs of urban, rural, and northern Aboriginal communities.

Improving recruitment and retention of Aboriginal peoples will increase the number of graduating Aboriginal nurses. Applying Archibald and Urion's (1995) finding that two thirds of Aboriginal graduates returned to work in Aboriginal communities, many graduating Aboriginal nurses would seek employment there.

1.2.3 Personal purposes

From the standpoint of a second-generation Euro-Canadian woman from a working class family, I entered graduate nursing education in the early 1990s. For my thesis, I conducted an ethnographic study that examined outpost nurses' worklife⁶ in

⁶ My interest in the worklife of northern outpost nurses was stimulated in 1992 at a conference in Thompson, Manitoba (north of the 53rd parallel). From the standpoint of a critical care nurse at a tertiary care hospital located in an urban centre (close to the 49th parallel), the stories from various northern outpost nurses inspired me. I found these nurses incredibly brave, adventuresome, and independent. As an urban nurse, I could not imagine how these people managed their worklives.

remote northern First Nations communities in Manitoba ⁷ (Martin, 1997; Martin & Gregory, 1996). Of the participating nurses, five identified themselves as Aboriginal. Four embraced the biomedical viewpoint about health, illness, and health care; the fifth, however, discussed the importance of incorporating the Medicine Wheel⁸, Aboriginal spirituality, and the Aboriginal traditional ways of healing into aspects of her nursing care. This finding caused me to question what social factors in nursing education influenced some Aboriginal nurses to highly regard the western biomedical viewpoint of health, illness, and health care. There may have been many reasons why those four Aboriginal nurses did not tell me about other health care beliefs and methods. Perhaps they were reticent to tell a white, middle-class, middle-aged woman in nursing academia about different worldviews and different ways of being a nurse. On the other hand, they may have assumed that I defined nursing from a western biomedical viewpoint and they wanted to please the researcher by telling me what they thought I wanted to hear. Whatever the reasons, my interest was further stimulated to understand how Aboriginal peoples learn how to become a nurse by studying their experiences from a local, translocal and extra local viewpoint.

During the late 1990s, I was a nurse educator in a baccalaureate-nursing program with ANS. I was poised to juggle culturally sensitive teaching with standards established by the school and professional nursing associations. I became interested in learning more about ANS' experiences, specifically (a) how ANS experience education

⁷ According to the 2001 census, Manitoba had the highest percentage of Aboriginal population (13.6%) among the provinces.

⁸ Please note that the Medicine Wheel originated in Southern Alberta, Wyoming, and the Dakotas. The Medicine Wheel illustrated the belief systems of some Aboriginal peoples and provided a framework for a balanced and healthy life. Although the Medicine Wheel is commonly acknowledged as a Pan-Aboriginal or Pan-Indigenous theoretical perspective for health beliefs and health promotion, all Aboriginal people do not rely upon it. For example, West Coast tribes did not use the Medicine Wheel in their teachings.

in a predominantly Euro-Canadian institution, and (b) what factors enhance or hamper ANS' experiences.

When conceptualizing the study, I corresponded with several Aboriginal nurses to acquire their opinions about the necessity to explore ANS' experiences. One Aboriginal nurse exclaimed that if an Aboriginal person conducted the research, the Aboriginal individual would experience a "backlash" when findings were reported. In fact, she perceived that an Aboriginal individual would be punished for "stating the truth." Because of this powerful statement, I was motivated to conduct a critical ethnography about ANS' experiences as my doctoral thesis. Further discussions about my standpoint as a non-Aboriginal person conducting research with Aboriginal peoples will be presented in Chapters Three and Four.

1.3 The need for a critical ethnography

"Interpretivist movements in anthropology and sociology have recently merged with neo-Marxist and feminist theory to produce a unique genre of research in the field of education known as 'critical ethnography'" (Anderson, 1989, p. 249). According to Carspecken (1996), critical ethnography can be applied to studies about human life and experience as it provides researchers with principles for conducting valid inquiries into any area of human experience. The aim of critical ethnography "is to theorize social structural constraints and human agency, as well as the interrelationship between structure and agency in order to consider paths towards empowerment of the researched" (Gordon, Holland & Lahelma, 2001, p. 193). Using critical ethnography as a method of inquiry, I remained sensitive to the dialectical relationship between the social structural constraints on the ANS as well as their personal agency.

In critical ethnography, studies of schools are combined with critical insights into how broader structures are mediated and produce change (Gordon, Holland & Lahelma, 2001). I used interviews, field notes, and textual analysis to explore ANS' everyday experience within the local setting of the participating schools of nursing and then examined how the ANS' everyday lives were shaped by the broader historical, social, cultural, political, and ideological context.

The study relied primarily upon specific tenets from several theoretical and methodological perspectives. I used tenets grasped from Aboriginal epistemologies,⁹ L. Smith's decolonizing methodologies for Indigenous peoples¹⁰ (1999), Ramsden's concept of cultural safety¹¹ (1993, 2002), and the social organization of knowledge¹² developed by Dorothy Smith (1986, 1987). Using these chosen tenets within my theoretical lens, "reality" was conceptualized as the everyday world, which is subjective, co-constructed, and highly influenced by its context (D. Smith, 1987). My theoretical lens provided a backdrop for me to critically examine ANS' experiences, social relations,

⁹ Epistemology refers to a branch of philosophy that inquires into the nature and possibility of knowledge (Mautner, 1996). Aboriginal epistemologies are distinct and deal with each Tribe's scope and limits of human knowledge, how it is acquired and possessed. However, commonalities exist and I relied on the unique commonalities within Aboriginal epistemology.

¹⁰ Linda Tuhiwai Smith (1999) articulated a research agenda for Indigenous peoples by Indigenous peoples. "Methodology is important because it frames the questions being asked, determines the set of instruments and methods to be employed and shapes the analysis" (L. Smith, 1999, p. 143). In particular, I found decolonizing methodologies for research and Indigenous peoples helpful in shaping my analysis.

¹¹ Irihapeti Ramsden (1993), the architect of cultural safety, contended that all nursing interactions were bicultural. Cultural safety required that nurses examine their own cultural realities, attitudes and behaviors and the impact that has on others. In contrast, cultural risk in nursing described a process in which people from one culture were demeaned, diminished and/or disempowered by the actions and the delivery systems of people from another culture (Ramsden, 1993).

¹² Dorothy Smith (1986, 1987), a Canadian sociologist, introduced a mode of inquiry referred to as institutional ethnography, to describe an "empirical investigation of linkages among local settings of everyday life, organizations, and translocal processes of administration and governance" (DeVault & McCoy, 2001, p. 751). Students of D. Smith described this theoretical perspective as the social organization of knowledge (Campbell & Manicom, 1995).

and the schools' textually mediated discourses¹³. Campbell and Gregor (2002) explained that social organization of knowledge "is the interplay of social relations, of people's ordinary activities being concerted and coordinated purposefully, that constitutes 'social organization' " (p. 27).¹⁴

A critical ethnography examining the local, translocal, and extra local aspects that shape and influence the everyday experiences of ANS was urgently required. Key stakeholders such as ANS, nurse educators, nursing education administrators, health services employers and Aboriginal leaders will benefit by learning more about factors that negatively and positively influence recruitment and retention from within the school of nursing and beyond. Key stakeholders require more information about factors that shape ANS' experiences to facilitate a positive transformation in the everyday experiences, in which Aboriginal peoples learn how to become a nurse.

1.4 Organization of the thesis

In Chapter One, I provide the background to the study, introduce the research topic and specify the research questions. The remainder of the dissertation will unfold to illustrate how dominant ideologies and nursing discourse influence the everyday experience of ANS and their social relations within Canadian schools of nursing.

¹³ In this study, texts are broadly defined and encompass an array of documents such as the school's mission statement, policies and procedures, nursing course descriptions, nursing course syllabus, nursing textbooks, media reports, clinical evaluation forms, websites, etc (D. Smith, 1999). Discourse refers to the "talk" as well as the texts of the institution. The "talk" includes professional nursing jargon and the language used by various social groups within the school of nursing (Campbell, 1998; Cummins, 1995; Hagey & Mackay, 2000).

¹⁴ Campbell and Gregor (2002) identified key concepts and assumptions that support D. Smith's research method. In D. Smith's social ontology, the social arises out of people's activities and through the ongoing and purposeful coordinating of those activities (i.e. concerting). "Analytically fundamental to this approach is an ontology that views the social as the concerting of people's activities" (DeVault & McCoy, 2001, p. 752). Concerting is synonymous with organizing or shaping people's activities in local settings (DeVault & McCoy, 2001).

In Chapter Two, I provide a review of the existing knowledge about ANS and nursing education. I begin by addressing the historical context of Aboriginal peoples in education with a synopsis of the history of Aboriginal peoples in Canadian nursing education. I examine how practices from the past continue to shape the educational experience of ANS. This examination provides the foundation to build a current examination of the everyday/every night world of ANS.

Chapter Three outlines the theoretical and methodological perspectives guiding this dissertation. Positioned within a static body of nursing scholarship, I explain the theoretical and methodological perspectives that influenced the way that I explored ANS' everyday experiences. In Chapter Four, I describe the method of inquiry – a critical ethnography guided by tenets from four theoretical and methodological perspectives: Aboriginal epistemologies, decolonizing methodologies for research and Indigenous peoples, cultural safety, and the social organization of knowledge. I tell the story of how this research study unfolded.

Chapters Five to Eight represent the empirical findings of this research. In Chapter Five, I focus on the everyday experience of ANS from the standpoint of ANS. In Chapter Six, I address the perspectives of nursing faculty in regard to factors shaping ANS' experiences. I identify social relations and explicate tensions between social groups within the schools of nursing in Chapter Five and Six. In Chapter Seven, I delineate the perspectives of key informants who were identified as individuals knowledgeable about contextual factors influencing ANS' educational experiences. In Chapter Eight, I describe the ways in which various hidden or embedded messages

within nursing discourse shape the experiences of ANS and their relations with other social groups.

In Chapter Nine, I discuss the findings in light of the theoretical and methodological perspectives that guided the work and the existing knowledge of ANS' experiences. In this process, I identify new knowledge and develop recommendations to facilitate an important yet complicated process that I refer to as decolonizing nursing education. Bold initiatives within the local, translocal, and extra local contexts will positively influence the everyday world of ANS and Non-Aboriginal nursing students, as well as the future health care of Aboriginal peoples in Canada.

1.5 Chapter summary

In this chapter, I provide the background to a critical ethnographic study of ANS' experiences in Canadian schools of nursing. By providing my purposes for conducting the study, I introduced the research topics: (a) ANS' experiences in Canadian schools of nursing, (b) intergroup relations from the standpoint of ANS, and (c) the context and nursing discourse that shapes nursing education of Aboriginal peoples. I conclude the chapter with an overview of the content of the dissertation.

According to Schmitt (2002), it is time to revalue nursing education research as various questions have been raised about the adequacy of present day nursing curricula and pedagogy. In light of difficulties in recruitment and retention of ANS, Canadian schools of nursing need new educational assumptions, innovative educational models, and the research capability to demonstrate which models are most efficient and effective for graduating more ANS.

2 REVIEW OF EXISTING KNOWLEDGE

On one hand there is very little research and educational literature on racism and Aboriginal people, yet on the other hand, the literature is filled with references to the effects of racism on Aboriginal people in educational institutions. This is a paradox, one that must be understood within larger social and political, national and academic commitments and traditions (St. Denis & Hampton, 2002, p. 4-5).

2.1 Introduction

The main purpose of this chapter is to provide a critical analysis of existing knowledge of ANS' experiences in Canadian schools of nursing. "A review of relevant literature is the basis for analysis and critique of what is already known about events of the kind that the researcher is exploring" (Campbell & Gregor, 2002, p. 50). It was necessary to unravel the existing knowledge about the educational experiences of ANS and decipher how it was socially constructed.

Firstly, I review the history of education of Canada's Aboriginal peoples. Guided by the tenets in Aboriginal epistemology, decolonizing research and Indigenous peoples, and cultural safety, I provide a brief overview of important historical events that greatly influence the educational experiences of Aboriginal peoples today. The history of Aboriginal education in Canada is presented using four overlapping phases: (1) traditional education prior to European contact, (2) colonial domination and segregation, (3) assimilation and acculturation, and (4) self-determination.

Secondly, I include a synopsis of the history of Aboriginal peoples in Canadian nursing education. Traditionally, nursing students were young, white, working or middle class women. Towards the latter portion of the twentieth century, Aboriginal peoples entered into the nursing profession. The review of the history of Aboriginal peoples in nursing education and practice revealed several concerns about ANS' experiences from the standpoint of Aboriginal nurses. Aboriginal nurses voiced their concerns about their experiences as nursing students: the trauma of leaving their home communities, being

scrutinized as "elitists" by community members, and struggling with inner conflicts due to different values, beliefs, and communication practices inherent in becoming a nurse.

Thirdly, I incorporated a tenet within Dorothy Smith's social organization of knowledge that guided me to critically review located literature in the post-secondary education of Aboriginal peoples, including nursing education. I synthesized and analyzed located literature in regards to what was present and what was absent (Marker, 1997). As suggested by Campbell & Gregor (2002), I did not cede authority to the literature as in conventional research studies. By reviewing existing knowledge about ANS' everyday life, I analyzed how the literature was socially constructed and organized. The analysis of existing knowledge of ANS' experiences facilitated the focus and direction of the research (Paterson, Osborne, & Gregory, 2004). The literature review helped me reflect on different ways of knowing about ANS' everyday experiences as well as affirmed that this doctoral thesis will add greatly to existing knowledge about ANS' everyday world (Campbell & Gregor, 2002).

Although there was extensive literature on Aboriginal issues, it was often difficult to locate. Information about Aboriginal peoples' experiences in postsecondary educational institutions was scattered throughout the biomedical and social science literature. Using Aboriginal, First Nations, Indian, Indigenous, Métis, Native, Native Alaskans, Native Americans and education as key subject terms, I conducted searches in the computerized library databases of the Cumulative Index of Nursing and Allied Health Literature (CINAHL), Educational Resources Information Centre (ERIC), Medline, and a web-based search through Google Scholar at the University of British Columbia library. I experienced great difficulty unearthing existing knowledge about the everyday experiences of Aboriginal peoples in postsecondary education. I often located research literature by reviewing reference lists and proceeding to acquire those

additional sources. When other researchers were informed about my research interest, they kindly shared their work with me (Health Canada, 2002; Marker, 1998, 2005; Walsch, 1995, Yurkovich, 1997). Browsing through libraries and bookstores, I located other literature about Aboriginal peoples' and Indigenous peoples' experiences in education.

Due to my standpoint as a middle-aged, middle class, white, female nurse educator with experience educating ANS, I worked closely with a research assistant¹⁵ and the Advisory Council¹⁶ who have Aboriginal ancestry. By collaborating with Aboriginal peoples who experienced nursing education, I focused on the standpoint of the ANS, 'unknown' aspects of ANS' everyday world, social relations in schools of nursing, and the social organization of knowledge (Campbell & Gregor, 2002). "The quality of research in First Nations education is not improved simply by having Aboriginal people doing the writing. It is improved by a more detailed analysis that includes the perspectives and location of both Natives and non-Natives" (Marker, 2001, p. 31).

2.2 Historical overviews

I begin this chapter with two brief historical overviews. In the first overview, I present a brief history of the education of Aboriginal peoples in Canada. In the second one, I address the history of Aboriginal peoples in Canadian nursing. As the historical context of Aboriginal education influences ANS experiences today, it was prudent for me to become knowledgeable about the events as well as how these events continue to shape the current experiences of Aboriginal peoples in postsecondary institutions.

¹⁵ Ms. Ardelle Kipling, RN, BN, was hired as the research assistant for this project. Ms. Kipling recruited and conducted interviews with 29 ANS and participated in analysis of several transcripts and field notes.

¹⁶ Advisory Council was comprised of five Aboriginal nurses who donated their time and expertise by reviewing issues regarding method of inquiry and preliminary findings.

2.2.1 Brief history of Aboriginal education

I divided this overview into four overlapping phases or eras: (1) traditional education – prior to European contact, (2) colonial domination and segregation, (3) assimilation and acculturation, and (4) self-determination (Kirkness, 1999). Following this section, I provide a review of the history of educating Aboriginal peoples in nursing.

To the American Indian, history is better explained as the importance of “experience.” People recall an experience in greater detail because of the emotions involved, vivid colors, familiar sounds described, and the people and/or beings involved. When retold, the experience comes alive again recreating the experience by evoking the emotions of the listeners, transcending past-present-future (Fixico, 2003, p. 22).

2.2.1.1 Traditional education: Prior to European contact

Prior to European contact, Aboriginal peoples implemented a form of education within their communities. Aboriginal peoples conducted and highly valued education in a manner that the community was the classroom, community members were the teachers, and each adult was responsible to ensure that every child learned how to live a fruitful life (Kirkness, 1999). “Education was not separated institutionally” from other aspects of Aboriginal peoples’ lives” (Wotherspoon & Satzewich, 2000, p. 116). Oral tradition was and remains the conduit for sharing knowledge within the Aboriginal community (Fixico, 2003). Central to each lesson was a belief in the existence of the Great Spirit, the totality of being, as well as the importance of relationships with the community, its members, and nature (Cajete, 1994; Kirkness, 1999). Traditional forms of education embodied a quest for self, individual and community survival, and wholeness in the context of the community and the land (Cajete, 1994, 2004).

The community became paramount by virtue of its role as repository and incubator of total tribal knowledge in the form of custom and culture. Each part of the community became an integral part of the whole flowing movement and was modeled on the inward wholeness and harmony (Ermine, 1995, p.105).

2.2.1.2 Colonial domination and segregation

The question of what actually constituted contact is an important one to clarify. Even though the year 1492 A.D. has become a powerful metaphor for European contact in the Americas, direct and regular contact between ethnically diverse groups of Europeans and Aboriginal peoples began at different times in different geographical locations. In Western Canada, contact generally began in the late eighteenth and early nineteenth centuries (Waldram, Herring, & Young, 1995). "Colonization refers to a process in which imperial powers established European sovereignty over the various areas of Canada" (Fleras & Elliott, 1999, p. 179). Generally, colonization entailed subjugation of a people who lived in a territory colonized by Europeans. Colonization, particularly, involved a process whereby: (a) Indigenous lands were confiscated, (b) the British legal system was imposed, (c) existing political structures were amalgamated, and (d) Indigenous peoples were assimilated into the dominant Eurocentric culture (Fleras & Elliott, 1999).

Some Aboriginal peoples signed treaties with the Crown or Canadian government and these individuals were referred to as "treaty Indians." Treaties covered most of Western Canada and Northern Ontario (excluding most of British Columbia) and served to remove Aboriginal peoples' entitlement to the land.

The Dominion of Canada became the colonizing arm of Great Britain, assuming the rights and responsibilities of the Crown in the Constitution Act of 1867. The Dominion of Canada imposed British rule through occupation, negotiated treaties, and

the threat of force. The 1867 Constitution Act enshrined federal responsibility for Aboriginal peoples by governing Aboriginal lands and affairs. "Canadian federalism tended to dismiss any thought of aboriginal peoples as political communities, preferring, instead, to see them as wards of the state with limited civil rights but fully entitled to federal custodial care" (Fleras & Elliott, 1999, p. 180). Sir John A. Macdonald espoused a "no more Indians" national policy (Fleras & Elliott, 1999).

The *Indian Act*, first passed in 1876, was designed to facilitate the administration of programs to the Indians, as well as the assimilation of Indians into mainstream society (Waldram, Herring, & Young, 1997). "The imposition of the Indian Act bestowed sweeping state powers to invade and regulate the minutest aspect of reserve life, even to the point of curbing constitutional and citizenship rights" (Fleras & Elliott, 1999, p. 180). The *Indian Act* of 1876 served to:

- define who came under its provision (status or non-status Indians, treaty versus non-treaty),
- designate what each status Indian was entitled to receive from government obligations,
- delineate how the local communities were to be governed – by elected Band Councils in contrast to traditional leadership,
- govern how reserve lands and resources were utilized, as well as,
- curtail economic opportunities in that Aboriginal peoples could not possess direct title to land or private property (Fleras & Elliott, 1999).

With European contact came the missionaries who initiated day or mission schools for the purpose of "civilizing" Aboriginal peoples (Kirkness, 1999). "Policies evolved from mission schools to industrial schools and then to what were called *residential schools* in Canada..." (Marker, 2005, p. 91). Aboriginal leaders placed much

faith in the missionaries who ran the first residential schools; Aboriginal leaders believed that the Crown and the church would provide for their welfare. Several centuries later, 130 Indian Residential Schools were established to conduct an extreme and tragic deculturation process (Barman, Hebert, & McCaskill, 1987; Kirkness, 1999; Ryan, 1992). Deculturation is a useful and meaningful concept when analyzing and describing the role of education in the spread of European culture through Canada (Ryan, 1992). "Residential schools left a potent legacy of language and culture loss, sexual abuse, disruption of parenting knowledge, and erosion of youth" (Marker, 2005, p. 90). Although many treaties guaranteed educational assistance, education was a pawn to extend white domination over the colonies that Europeans claimed for themselves while treaty promises never materialized (James, 1992; Ryan, 1992).

Indian Residential Schools were located mainly in Western Canada (Indian Residential School Survivor Society, 2004). In 1907, the Canadian press acknowledged that the mortality rate in residential schools was higher than 50% due to illness, physical violence, attempts to escape, or suicide with minimal reaction by the public (Annett, 2001). Despite knowledge of high mortality rates, the Federal Government of Canada amended the Indian Act in 1920 making it mandatory for Aboriginal children to attend residential schools. Aboriginal children relocated to schools hundreds to thousands of miles away from their homes.

Government policy stated that the schools could not educate Aboriginal children "above the possibilities of their station." Formal schooling consisted primarily of training Aboriginal peoples for subordinate roles that served the dominant culture and engendered "in these people an allegiance to a particular and very different political, economic, and moral way of life" (Ryan, 1992, p. 92). Thus, the curriculum included moral training through physical labor, academic instruction to a Grade 3 level, and

industrial training for subordinate positions (Indian Residential School Survivor Society, 2004).

Although the 1928 publication of the Miriam Report further exposed deplorable conditions in Residential schools, this format for educating Canada's Aboriginal children continued until the 1970s when the National Indian Brotherhood lobbied for Aboriginal control of their own education. Unfortunately, the last Indian Residential School, located in Saskatchewan, did not close its doors until 1996 (Government of Canada, 2003). While the residential schools in Canada aimed to assimilate Aboriginal people by eradicating their language and culture, "the public histories of struggle for Aboriginal self-determination was apparent and 'education' was identified as both an assimilative force to be resisted and as an indigenous force to be reclaimed" (Marker, 2005, p. 93).

"The federal government has continually said that education is a privilege, not a right" (Henderson, 1995, p. 245). The government's position on Aboriginal education stems from British law and its premise that education is a product of the family's socioeconomic status, parental goals for the child, and the individual's cognitive talent; this position juxtaposed Aboriginal peoples' belief that education was a right for all (Henderson, 1995).

2.2.1.3 Assimilation

The third phase or era in the history of Aboriginal education was referred to as assimilation and continued acculturation. To accommodate the closure of residential schools, a number of federally run Indian Day Schools were established in Aboriginal communities (Kirkness, 1999). Concomitantly, there was a policy of integration in which Aboriginal children were assimilated through education into the dominant Euro-Canadian culture (Huff, 1997; Kirkness, 1999). The approach to Aboriginal education was notably paternalistic, coercive, racist, discriminatory, and assimilative (Burns, 1998;

Marker, 2005). Only a decade ago, Hampton (1995) described the status of education as “now as in the past hundred years, Indian education means the education of Indians by non-Indians using non-Indian methods” (p. 6).

While historical studies of Aboriginal education focused primarily on residential schooling, Marker (2005) argued for more research on the recent past, specifically at sites where secondary schools served as dress rehearsals for the inequalities and scripted adult roles that Aboriginal and non-Aboriginal adolescents would soon occupy. Using historical research, Marker (2005) explored Lummi adolescents’ experiences 30 years ago and found that these Aboriginal teens were struggling to attain their identity and young adulthood under conditions whereby white teachers and students were “intent on maintaining both economic and cultural privilege” (p. 107). In comparison to the Lummi case in the Coast Salish community of the United States, Furniss (1999) described recent cross-cultural tensions in a Western Canadian high school:

These different perspectives on racism were clearly evident in a 1992 assessment of the needs of Aboriginal students in the Cariboo-Chilcotin School District. An educational consultant surveyed Aboriginal students, their families, district educational staff, principals, teachers, and counselors. Students and their families reported that racial discrimination – ranging in expression from direct racial taunts to more subtle forms of being excluded or being expected to be low achievers – was among the most important problems that Aboriginal students faced. In contrast, few of the teachers, and none of the administrators, identified racial discrimination as an issue facing Aboriginal students (p. 125-6 as cited in Marker, 2005).

Similar to Non-Aboriginal peoples, many Aboriginal peoples believe that postsecondary education has the capacity to equip them with the knowledge and skills

required to get along in today's world. Ironically enough, formal education, conducted as it is within a Euro-Western tradition that controls the conditions of learning, may also require substantial adjustment on the part of Aboriginal students, an adjustment that may have a decisive impact on their ability to be successful in these programs even if programs propose to cater to Aboriginal peoples (Ryan, 1995). According to Health Canada (2002), only three percent of Aboriginal peoples completed a university degree as compared to 13% of the overall Canadian population. In contrast to Euro-Canadian university students, Aboriginal students rarely come from affluent families that may provide financial support for their post-secondary education. Student loans may be out of the question in that Aboriginal students' debt load may be too high by the time they complete their nursing degree and secure a paying job.

Public education has hidden or dismissed the legacy of having confiscated Indian lands and the subsequent colonization of Aboriginal peoples (Huff, 1997). Textbooks buried the stark reality that the wealth of Canada was derived from Indian lands and labor (Huff, 1997). Huff (1997) noted that public education has paid "lip service" to accepting culturally diverse ideas of Aboriginal peoples, who justifiably resisted being tossed into a "racial food processor." The average Canadian was found to be divorced from the historic past and conflicts which were rooted in the past. "It serves no purpose to wax nostalgic about the successes education enjoyed transforming European immigrants into the middle and upper classes, because that model lacks one variable, race" (Huff, 1997, p. 159).

Euro-Canadian teachers and administrators under-estimated the resilience of Aboriginal peoples. Aboriginal peoples' thinking could not be totally altered to Euro-Canadian ways (Fixico, 2003). Aboriginal peoples were now equipped with dual

perspectives, from their tribal view and from the dominant "western" scientific viewpoint (Fixico, 2003).

2.2.1.4 Self-determination

Within the history of Aboriginal education in Canada is the fourth and final phase referred to as self-determination. Recently, the necessity of self-determination surfaced as some Canadians began to identify the importance in Aboriginal peoples having ultimate control over their own education. I explain how recent historical events led towards Aboriginal self-determination.

The National Indian Brotherhood prepared a report in 1971 about the educational concerns of Aboriginal peoples (Barman, Hebert, & McCaskill, 1987). The report indicated that church and state failed to provide an effective educational program for Aboriginal peoples as promised in many treaties. In 1973, the Minister of Indian Affairs provided official departmental recognition to the policy of *Indian Control of Indian Education*, based on two principles: (a) parental responsibility, and (b) local control (Kirkness, 1999). Implementation of the policy resulted in a range of educational programs from small to large additions of Aboriginal peoples' content and pedagogy in the curricula (Barman, Hebert, & McCaskill, 1987). Three main areas of concern emerged following the implementation of this policy: administration, funding, and legislation (Haig-Brown, 1995; Kirkness, 1999).

Unfortunately, Aboriginal adolescents continued to exit from high schools at the rate of 70% (Downey, 2004; Health Canada, 2002). By not obtaining a high school diploma, many Aboriginal adolescents were destined to enter a vicious cycle of poverty and unemployment (Health Canada, 2002). Deprez and Lithman (1973) argued that the success of any educational effort depended on the overall employment opportunities at

the level of the home Aboriginal community and beyond. If there is no hope for a better life through gainful employment, why remain in a Euro-Canadian secondary school system? Marker (2001) examined how economic pressures and political forces constrained Aboriginal educational self-determination. Local cultural responsiveness to celebrating and promoting language and identity was resisted by white institutional hegemony as funding and accreditation continued to be ultimately administered by government or government agencies.

The National Aboriginal Health Organization, with an objective to increase the participation of Aboriginal peoples in health careers, promoted the incorporation of both traditional knowledge and western-based perspectives in elementary through high school curricula to improve the educational standards and experiences of Aboriginal children and adolescents (Downey, 2004). By integrating Aboriginal languages in schools, students' attendance improved with an increase in students' self-esteem, academic achievement, and graduation rate (Downey, 2004).

In terms of self-determination of 'higher learning,' Marker (2004a) identified considerations that were structural and conceptual challenges for collaborating with Aboriginal peoples about their postsecondary educational experiences. In undergraduate and graduate studies, Aboriginal peoples experienced a cultural clash around the themes of research, methodology, theory, and community. This cultural clash occurred at the deepest levels of ontological and epistemological assumptions. "Interrupting the lemming-like journey of Western technocratic knowledge could become the most powerful and enduring legacy yet of First Nations education" (Marker, 2004a, p. 187). By maintaining a strong Eurocentric perspective in higher education, Marker (2004b) identified that today's society continued to be complacent in facilitating colonial dominance.

2.2.2 History of Aboriginal Peoples in Canadian nursing

In this overview, I continue to tell the story of the historical context shaping Aboriginal peoples' experiences in nursing education. Traditionally, North American schools of nursing recruited and attracted female, white, middle-class students (Brink, 1990; Dickerson & Neary, 1999; Furuta & Lipson, 1990). In 1982, there were approximately 200 Aboriginal health care professionals in Canada (Aboriginal Nurses Association of Canada, 2004a; Thomlinson, 1992). By 1992, there were approximately 350 Aboriginal nurses, accounting for less than 1% of Canadian nurses, which was similar to American nursing demographics (Buerhaus & Auerbach, 1999). In the United States and Canada, Indigenous peoples were the least represented of all minority groups, including men, in schools of nursing (Buerhaus & Auerbach, 1999; Canadian Nurses Association and Canadian Association of Schools of Nursing, 2004; Crow, 1993; Dickerson, Neary, & Hyche-Johnson, 2000; Martin, 1997; Plumbo, 1995; Thomlinson, 1992).

The history of Aboriginal nurses in Canada has been mired with political and financial struggles. In 1975, several Aboriginal nurses came together with a common concern to improve the health of Aboriginal peoples and formed the Registered Nurses of Canadian Indian Ancestry. The organization was renamed the Indian and Inuit Nurses of Canada and today is known as the Aboriginal Nurses Association of Canada (ANAC).

In the early years of its formation, ANAC experienced political and financial struggles, but the organization was successful in meeting its objectives to improve the health of Aboriginal peoples and recruit more Aboriginal peoples into health professions. ANAC members believed in the principle of Aboriginal control of Aboriginal

organizations and resisted using federal and provincial nursing associations as an avenue to voice their concerns about Aboriginal health issues (ANAC, 2004a, 2004b).

To celebrate its efforts and stimulate recruitment of Aboriginal peoples into nursing, the ANAC published profiles of its members (1995). "These nurses shared their individual histories, career goals, and a vision of improved health for Aboriginal people" (Martin, 1997, p. 22). I identified some concerns about the educational experiences of ANS from these and other anecdotal reports by Canada's Aboriginal nurses: (a) the trauma of leaving home communities to acquire a nursing education, (b) being scrutinized as "elitists" by community members because of an educational experience "outside" of the reservation, and (c) inner conflicts due to different values, beliefs, and communication practices (ANAC, 1995; Crow, 1993; Goodwill, 1992; Hart, 2002; Martin, 1997; Thompson, 1993).

I attended a recent symposium about Aboriginal nursing education held by the Aboriginal Nurses Association of Canada (ANAC) in Ottawa, Canada (2005). Participants included nursing administrators, educators, Aboriginal nurses, and ANS. Some participants expressed concern that nurse educators and administrators sustain acculturation of ANS in their nursing programs by forcing them to conform to the dominant group's beliefs, values, and communication styles. Participants at the symposium perceived that nursing curricula was based upon the health care needs of Euro-Canadians, while nursing pedagogy was primarily focused on the learning styles of Euro-Canadians.

Strategies were discussed to improve recruitment and retention of Aboriginal peoples in nursing. The first strategy involved funding a position within the ANAC, whereby the incumbent would lobby the federal government to provide financial support to all ANS. This strategy was recommended by Health Canada (2002) in that the key

concern of ANS was inadequate funding. The second strategy was to lobby the Canadian Association of Schools of Nursing (CASN) to adopt accreditation protocols, whereby schools must include mandatory courses about Aboriginal culture and Aboriginal health beliefs and issues. "Curriculum that promotes and includes Aboriginal cultures to reflect the diversity across the country is critical" (ANAC, 2005, p. 4). CASN, in turn, would collaborate with professional nursing associations and the National Aboriginal Health Organization to establish criteria to evaluate culturally safe nursing practice of all graduates. Cultural safety¹⁷ was deemed crucial to delivery of professional nursing care to Aboriginal peoples (Browne, Fiske, & Thomas, 2000; Coup, 1994; Dowd & Eckerman, 1992; Joho & Ormsby, 2000; Kavanaugh, Absalom, Beil & Schliessmann, 1999; Keitner, 1999; Pinikahana, Manias, & Happell, 2003; Polaschek, 1998; Smye & Browne, 2002; Weaver, 1999).

Given the backdrop of the history of Aboriginal education in Canada and the history of Aboriginal peoples in Canadian nursing, I reflected upon how the historical context influenced ANS' experiences. The first historical phase of traditional education is important in that ANS may or may not be aware of Aboriginal health beliefs, communication styles, and traditional healing methods. Since Aboriginal health care issues are paramount in Canada, a culturally sensitive approach to information about traditional health beliefs, communication styles, and healing methods would be beneficial to all nursing students. Furthermore, an understanding of the influence of colonization and neo-colonialism on the overall health status of Aboriginal peoples in Canada and the student-teacher relationship would enhance nursing practice and learning environments. By placing Aboriginal health and learning in its historical

¹⁷ According to Polaschek (1998), culturally safe nursing practice involves actions and behaviors that recognize, respect and nurture the unique cultural identity of minority patients and safety meets their needs, expectations and rights.

context, nurse educators and students would incorporate more sensitive ways of promoting health and learning. The fourth historical phase of self-determination promoted the vision that Aboriginal nurses would have ultimate control over their organizations. This vision may prove to influence the development and implementation of curriculum and educational policies that enhance recruitment and retention of Aboriginal peoples in schools of nursing. Nurse educators would benefit by collaborating with Aboriginal nurses in developing curriculum content and teaching strategies that promote inclusiveness.

2.3 The social construction of existing knowledge

In this section, I provide a review of the existing knowledge of ANS' experiences. I reviewed existing literature to grasp a sense of the social construction of ANS' experiences and factors that influenced those experiences. Ten descriptive studies were located that examined the educational experiences of ANS in undergraduate and graduate nursing programs in North America (Care, 2003; Dickerson, Neary, & Hyche-Johnson, 2000; Health Canada, 2002; Kulig, 1987; McLeland, 2005; Ryan, 1992, 1995; Usher, Lindsay, Miller & Miller, 2005; Walsch, 1995; Weaver, 2001; Yurkovich, 1997). While most of the studies used qualitative research methods, Kulig (1987) and Weaver (2001) explored ANS' experiences using survey methods. Two other studies explored the essence of practicing nursing as an Aboriginal person (Plumbo, 1995; Struthers & Littlejohn, 1999).

Along with these 12 studies of ANS' experiences and Aboriginal nursing, I reviewed literature about postsecondary education of Aboriginal peoples. In the following sections, I offer a synthesis of existing knowledge of the ANS' experiences. I describe barriers that contributed to a negative educational experience under the theme

called "Struggles" as it reflected a life cycle event from Aboriginal epistemology. I refer to all factors that contributed to a positive educational experience under "Survival."

In the process of critically analyzing existing knowledge of Aboriginal peoples' experiences in postsecondary institutions, I was also looking for what was missing (Campbell & Gregor, 2002; Marker, 1997). In the section entitled, "What was missing?" I discuss how intergroup relations and racism may influence ANS' experiences. Although intergroup relations and institutional racism were identified in the literature about postsecondary education, these important influences were rarely identified in the nursing literature (Huff, 1997; Jackson, Smith & Hill, 2003; Law, Phillips & Turney, 2004; Makinauk, 2003; Marker, 2000; Penketh, 2000).

2.3.1 Struggles

A resounding theme in the literature from adult education is that Aboriginal peoples experience many struggles in their attempts to attain post-secondary education (Archibald & Urion, 1995; Arvizu, 1995; Crow, 1993; Hoover & Jacobs, 1992; Hornett, 1989; Huff, 1997; Huffman, 1991; Jackson, Smith & Hill, 2003; James, 1992; Kirkness & Barnhardt, 1991; Kleinfeld, Cooper & Kyle, 1987; Lin, Lacounte, & Eder, 1988; Long & Nelson, 1999; Makinauk, 2003; Marker, 1997; More, 1987; Perry, 2002; Reyhner, 1992; Rhodes, 1998; Ryan, 1995; Sawyer, 1990; St. Denis & Hampton, 2002; Tate & Schwarz, 1993; Tierney, 1992). Inter-related struggles identified in the literature were: (a) inadequate high school preparation, (b) lack of support services, (c) rigid institutional policies and procedures, (d) ethnocentrism, and finally, (e) inadequate funding.

2.3.1.1 Inadequate primary and secondary education

Four North American studies identified that Aboriginal peoples from reserves faced difficulties from the very beginning of their postsecondary education because their

high school preparation provided them with substandard English, mathematical, and scientific backgrounds (Health Canada, 2002; Deprez & Lithman, 1973; Walsch, 1995; Yurkovich, 1997). Although Indigenous nursing students in Australia indicated that they also struggled with inadequate educational preparation, the rationale for this issue was not clarified (Usher, Lindsay, Miller, & Miller, 2005).

Aboriginal peoples who received their secondary education in Aboriginal communities were inadequately prepared academically for post-secondary education (Health Canada, 2002). Grade equivalency was identified to be widely variable. According to one participant, "38% of First Nations students are completing high school, 8.2% have the required courses for university in British Columbia" (Health Canada, 2002, p. 77). Frequently, federally-funded high schools were not meeting the same educational standards as provincial schools. This actuality was a crucial factor that was repeatedly brought forward to the researchers (Health Canada, 2002). Because the high school educational standards and resources for many northern communities were lower than their urban counterparts, Aboriginal peoples were often required to attend a "bridging" program (Faculty of Nursing, University of Manitoba, 2000; Health Canada, 2002; James, 1992; Walsch, 1995). Health Canada (2002) recommended that the federal, provincial, and territorial education departments in partnership with Aboriginal communities make tutors readily available to Aboriginal high school students, especially for English, math, and science.

Other studies indicated that recruitment, retention, and graduation of Aboriginal high school students were enhanced when Aboriginal cultural content was integrated into the Euro-Canadian educational system (Downey, 2004; Marker, 1997). Success of secondary and postsecondary education depended upon the overall employment context for Aboriginal peoples, which remained bleak in many Aboriginal communities

(Deprez & Lithman, 1973). However, many Aboriginal peoples were aware of the current nursing shortage and the related nursing positions available in Aboriginal and Non-Aboriginal communities.

In Yurkovich's study (1997), 17 out of 18 ANS indicated that their high school experience was predominantly comprised of the Euro-American culture (Yurkovich, 1997). One participant voiced her anger in response to discriminatory practices and attitudes of a high school advisor. In this example, I depict how racism over-shadowed inadequate high school preparation. This ANS stated,

My friends had taken algebra and chemistry, and he wouldn't let me take those classes and I asked him why....He said because I was Indian and our stats show that by the time you are 17 or 18 you will be pregnant and drop out of school. So we don't spend our precious resources on people who will drop out (Yurkovich, 1997, p. 97).

2.3.1.2 Lack of support services

Canadian schools of nursing participated in a survey to determine what progress had occurred with respect to recruitment and retention of ANS (Health Canada, 2002). An improvement was identified in that general Aboriginal student support services existed in almost 91% of participating institutions (universities, affiliated colleges); whereas, general access programs were limited in that they were occurring in only 37% of these facilities (Kleinfeld, Cooper & Kyle, 1987; Weaver, 2001). General access programs were available to Aboriginal and non-Aboriginal students who had been "disadvantaged" academically, socially, economically, and politically (Health Canada, 2002). General access programs provided these students with academic supports such as tutors and personal supports such as councilors. Unfortunately, some universities and colleges reported that general access students rarely enroll in nursing programs (Health Canada, 2002). With inadequate high school preparation, it was important for postsecondary institutions to support general access programs in that transition years

were required to prepare Aboriginal students for mainstream university or college admission.

Specific access programs in schools of nursing were severely lacking (Health Canada, 2002). Only two jurisdictions offered specific access programs in schools of nursing: Saskatchewan and Manitoba - two provinces with the highest percentage of Aboriginal peoples in their population, given that the overall Aboriginal population has grown to be approximately 13.6%. Nursing access programs offered support to ANS throughout the duration of their preparatory year and the nursing program. Jurisdictions with nursing access programs had more ANS than those schools of nursing where no such program existed. "It is worth noting that it is the colleges that have taken a leadership role in preparing Aboriginal people for university-level nursing studies in Canada" (Health Canada, 2002, p. 60).

Seventy percent of Canadian Association of Schools of Nursing (CASN) members did not designate any specific seats in their schools of nursing for Aboriginal peoples. Only nine schools of nursing set aside one to five seats for Aboriginal peoples (Health Canada, 2002). Two schools of nursing admitted all Aboriginal students who successfully completed a bridging program (Health Canada, 2002).

Although some schools of nursing claimed to recognize the Aboriginal perspective, institutional actions and behaviors were incongruent with this claim (Health Canada, 2002). ANS noted that Aboriginal approaches and perspectives always required justification. Institutional racism was noted to over-shadow lack of support services for Aboriginal peoples in post-secondary education (Huff, 1997; Jackson, Smith & Hill, 2003; Marker, 2004b).

Once Aboriginal students were accepted into a nursing program, they often needed to relocate and rearrange housing, childcare, access to public transportation

within the constraints of their limited budget (Health Canada, 2002; Ryan, 1995).

Problems associated with housing, family, finances, and racism generated considerable additional struggles for these students, which in turn, affected their ability to progress through their nursing program. Ryan (1995) described the experiences of ANS as they adapted to life in an urban setting: Finding a suitable house or apartment was complicated by discriminating landlords. "Many Native students have faced situations where they are told on the phone that accommodation is available, only to be informed when they show up in person that it has already been claimed (Ryan, 1995, p. 215-216). Adapting to life in an urban setting dominated by Euro-Canadians involved new experiences of discrimination (Ryan, 1995).

Approximately 80% of ANS identified themselves as parents (Health Canada, 2002). Childcare issues interfered with ANS' ability to fully participate and meet some practical obligations of being a student nurse (Health Canada, 2002). "Family concerns retain a high priority for students throughout their tenure" (Ryan, 1995, p. 217). Many children of the ANS grew up in a milieu where rules and conventions are substantially different from those they encounter in an urban setting. Confronting racism is the most unsettling obstacle for the children and their parents (Jackson, Smith & Hill, 2003; Ryan, 1995).

In lieu of Health Canada's finding that there were only 23 Aboriginal nursing faculty members in Canada, several ANS identified the need for Aboriginal tutors and student advisors within the schools of nursing (2002). Participants suggested that nursing faculties should establish good working relationships with Aboriginal student services and ANS to meet the needs of ANS (Dickerson, Neary & Hyche-Johnson, 2000; Jackson, Smith & Hill, 2003).

2.3.1.3 Rigid institutional policies and procedures

Many researchers identified rigid institutional policies and procedures as a contributing factor in the experience of a hostile postsecondary environment for Aboriginal students (Dickerson, Neary, & Hyche-Johnson, 2000; Health Canada, 2002; Huff, 1997; Huffman, 1991; Kirkness & Barnhardt, 1991; Marker, 2004a; Tierney, 1992; Walsch, 1995; Womack, 1997; Yurkovich, 1997). Rigid institutional policies and procedures were strongly associated with ethnocentrism (please see page 36) as revealed in entrance requirements, failure to grant leaves of absence for family/community losses, and strict time frames for completion of postsecondary programs. ANS' narratives revealed their perceptions of a rigid academic environment with a set of specific standards, in which there was only one way to learn. ANS believed that their learning environment had a strong traditional approach, which required a sequence of learning tasks in a specific manner (Dickerson, Neary & Hyche-Johnson, 2000).

Blame was conveyed to Aboriginal students through rigid institutional policies and procedures (granting or not granting a leave of absence, length of time for program) that discounted students' values of family and community. Defining the problem in terms of poor retention, low achievement, and high attrition placed the onus of adjustment on Aboriginal students. Kirkness and Barnhardt (1991) advocated changing the language to facilitating easy access, leaves of absences, and returning access to place the onus of adjustment on the institution. However, they questioned if those who were in a position to make a difference in the education of Aboriginal peoples "will seize the opportunity and overcome institutional inertia" (Kirkness & Barnhardt, 1991, p. 14). By using an Aboriginal perspective and applying respect, relevance, reciprocity, and

responsibility to postsecondary institutions and higher education, Kirkness and Barnhardt (1991) identified that the institution and the entire community would benefit.

2.3.1.4 Ethnocentrism

I use the phrase, ethnocentrism, to refer to the conscious and subconscious viewpoint that one's way to "see" the world, science, knowledge, and education is superior to others' viewpoints. I found that the literature indicated there was "only one way" of thinking, communicating, learning, acting, and being a nurse. This ethnocentric perspective existed in nursing education at multiple levels. "Native American students described an Anglo-centric focus in the classroom that reflected a Western medicine model and differed from their traditional model. Students were sensitive to this difference and viewed it personally" (Dickerson, Neary & Hyche-Johnson, 2000, p. 192).

Ryan (1992) identified that the dominant Eurocentric perspective was reflected in nursing ideology and practices of Non-Aboriginal nursing students, nurse educators, health care practitioners, as well as educational and hospital administrators and their institutions. Ethnocentric viewpoints and behaviors affected intergroup relations: student-student, student-patient, student-nurse, and student-teacher. Representations and enactments of ethnocentric perspectives occurred in the nursing curriculum, schools' policies and procedures, policies within the professional nursing associations and unions, as well as the images and behaviors present in society (Dickerson & Neary, 1999; Dickerson, Neary, & Hyche-Johnson, 2000; Hagey & MacKay, 2000; Health Canada, 2002; McLeland, 2005; Paterson, Osborne, & Gregory, 2004; Ryan, 1992; Weaver, 2001).

Eurocentric ideology perpetuated the dismissal of the importance of Aboriginal cultures' values, ways of interpersonal communication, strategies for gathering information, and the manner in which many people solve problems (Adams, 1992;

Dickerson, Neary, & Hyche-Johnson, 2000; Jackson, Smith & Hill, 2003; Ryan, 1992). ANS perceived that the academic environment was rigid with only one way to learn, one way to think, and one way to behave like a nurse (Dickerson, Neary, & Hyche-Johnson, 2000; Health Canada, 2002; Paterson, Osborne, & Gregory, 2004; Ryan, 1992). A Euro-Canadian perspective within schools of nursing forced ANS to conform to dominant group's communication practices. According to several ANS, they tended to be more reflective in their listening in classrooms, whereas nursing faculty expected them to demonstrate more assertiveness and "perky" participation (Health Canada, 2002; Jackson, Hill & Smith, 2003). "The teachers think there is something wrong with a Native student because they do not talk, or they do not communicate [in ways that teachers expect]" (Ryan, 1992, p. 98).

ANS perceived nursing faculty as strict evaluators who concentrated solely on the ANS attaining "white" standards of nursing practice regardless of individual cultural differences. ANS perceived that feedback from faculty was consistently negative, judgmental, and disrespectful (Dickerson, Neary, & Hyche-Johnson, 2000).

Several sources critiqued conventional culturalist¹⁸ approaches to address the issue of race, ethnicity, and health in nursing education (Culley, 1996, 1997; Paterson, Osborne & Gregory, 2004; Tullman, 1992). "Within the professional discourse of nursing, the issue of 'race' and health is dominated by the discourse of 'culture', 'cultural sensitivity' and 'cultural awareness'" (Culley, 1997, p. 30). By solely adopting a cultural awareness approach to Aboriginal peoples, the significance of the historical, sociopolitical and structural aspects of society was denied. Complex social phenomena

¹⁸ Cultural pluralism and essentialism are two aspects of culturalist approaches. By focusing on culture, the significance of the political and structural aspects of society and power relationships between health care providers and patients are ignored and culture, itself, becomes problematic. Health differences tend to be related to cultural differences and/or deficits. With an essentialist concept of culture, the Aboriginal culture is viewed as an absolute and fixed category (Culley, 1997).

such as Aboriginal health and nursing were deconstructed to grossly over-generalized stereotypes as viewed by the dominant Euro-Canadian group. A culturalist approach in nursing education tended to perpetuate denial of the power relations between Aboriginal peoples and the dominant Euro-Canadian culture and the power relations inherent between student and teacher, patient and health care provider.

Within nursing education, there was an over-emphasis on culture and language rather than equal opportunities and anti-racism. Although cultural awareness education for nursing students was important since aspects of culture had bearings on health beliefs, behaviors, and utilization of services, it was noted as vital that nursing education about race, ethnicity, and health was conducted in a critical way that promoted the interest of minority groups such as Aboriginal peoples (Paterson, Gregory & Osborne, 2004).

I found that Aboriginal students were identified as "other than white" and from the standpoint of ANS, feelings of alienation were described (Dickerson, Neary, & Hyche-Johnson, 2000). Within the historical context, a hierarchy of white Euro-Canadians, white immigrants, immigrants of color, gay and lesbian students, I identified Aboriginal peoples as being positioned at the lowest status of "other than white" (as noted by Lithman in 1973). "Whiteness, which includes 'acting white', is required for full assimilation into the nursing establishment on the part of students, faculty and clinical nurses regardless of color" (Puzan, 2003, p. 195). Being a "visible" Aboriginal person placed ANS in a more precarious position than a lighter skinned "non-visible" Aboriginal person (St. Denis & Hampton, 2002).

Aboriginal students were examined for their "different" learning styles (Crow, 1993; James, 1992; More, 1987; Reyhner, 1992; Rhodes, 1998), "different" worldviews (Crow, 1993; Dickerson & Neary, 1999; Plumbo, 1995), and resulting value conflicts

within a postsecondary environment (Dickerson & Neary, 1999; Dickerson, Neary, & Hyche-Johnson, 2000; Health Canada, 2002; Kavanagh, Absalom, Beil, & Schliessmann, 1999; Lin, Lacounte, & Eder, 1988; Walsch, 1995; Weaver, 2001; Yurkovich, 1997). By placing the onus of adjustment on the student for being other than white or different from the dominant group, a hostile learning environment ensued (Canales, 2000; Health Canada, 2002; Kirkness & Barnhardt, 1991; Ryan, 1992; Walsch, 1995; Womack, 1997; Yurkovich, 1997). Jackson, Smith and Hill (2003) noted that American Indian postsecondary students described a non-linear path in their journey to acquire a college degree. The students valued the cyclic rather than Euro-Canadian linear progressions and they valued the present more than the Euro-Canadian focus on the future.

In 1976, Ryan described a process in which researchers and theorists examined society's problems and then attributed the problems to the affected individuals (as cited in Jackson, 1993). This process was referred to as victim blaming and with an element of cynicism, Ryan listed these steps:

First, identify a social problem. Second, study those affected by the problem and discover in what ways they are different from the rest of us as a consequence of deprivation and injustice. Third, define the difference as a cause of the social problem itself. Invent a humanitarian action program to correct the differences. To blame the victim is to conduct and interpret research that shows how "these people" think in different values, seek different goals, and learn different truths (Ryan, 1976, p. 215 as cited in Jackson, 1993, p. 373).

Traditionally, the problem of recruitment and retention of Aboriginal peoples in postsecondary education involved a similar process by blaming students. Educators used these terms to describe ANS' performances: low achievement, high attrition, poor

retention, and weak persistence (Kulig & Thorpe, 1996). This language placed the onus of adjustment on ANS students and strengthened the discursive power of the educational institution in that the school was viewed as superior and virtuous (Cannella & Reif, 1994; Cummins, 1995; Funkhouser & Moser, 1990; Huff, 1997; Kirkness & Barnhardt, 1991; Ladson-Billings, 1995; Phillips, 2000; Ryan, 1992; Womack, 1997).

Despite the growing Aboriginal population in Canada and their health care needs, nursing curricula strongly reflected a biomedical view of health, illness, and health care that excluded information about Aboriginal health (Campbell & Jackson, 1992; Crow, 1993; Culley, 1996, 1997; Health Canada, 2002; Jackson, 1993; Puzan, 2003; Roberson & Kelley, 1996; Ryan, 1992; Weaver, 2001; Yoder, 1996; Yurkovich, 1997). Weaver (2001) found that 40 ANS and Aboriginal nurses indicated that 35% of their nursing programs lacked content on Native America health issues. "Consequently, students and teachers are socialized to accept and validate particular discourses, ontologies, and epistemologies without capacity or motivation to challenge their legitimacy" (Puzan, 2003, p. 196). This finding was congruent with results of a survey of family medicine programs in Canada (Redwood-Campbell, MacDonald, & Moore, 1999). All Canadian family medicine program directors were surveyed with a 100% response rate. Findings indicated that no programs had formal objectives regarding Aboriginal health issues. Many Canadian family medicine programs provided "*some* exposure to aboriginal health issues, but most need more expertise and direction on these issues" (Redwood-Campbell, MacDonald, & Moore, 1999, p. 325).

2.3.1.5 Inadequate funding

In 1977, the Department of Indian and Northern Development (DIAND) implemented the Post Secondary Education Assistance Program (PSEAP), designed to assist registered Indian and Inuit peoples to acquire postsecondary education (Health

Canada, 2002). High school graduates were invited to apply to the PSEAP and the DIAND initially administered the program. At first, students were accountable to pay their academic expenses from the fund with the expectation that a basic level of academic achievement was maintained (Health Canada, 2002).

In 1989, the DIAND implemented a revised postsecondary support program (Health Canada, 2002). New funding criteria along with a maximum allowance and duration were established. Restrictions were placed on student eligibility, while daycare and rental subsidies were removed. Types of assistance for full-time students were altered to include: (a) tuition assistance (registration, tuition fees, supplies and textbooks), (b) travel costs for one return visit for the student and their dependents to their community per semester, and (c) living expenses with maximum monthly allowances for students and their dependents (Health Canada, 2002). "Although DIAND has continually increased its level of funding for education, it remains at a 2% growth rate" (Health Canada, 2002, p. 159) with the level of funding remaining the same since 1989. Post-secondary education funding to all Aboriginal communities has not reflected the costs of inflation and the increasing number of Aboriginal peoples who wished to pursue postsecondary education. Although the DIAND allocated \$228 million for postsecondary education in 2000-2001, an estimated number of 8,475 Aboriginal peoples were unable to access postsecondary funding (Health Canada, 2002).

The federal government continued to control postsecondary funds for First Nations and Inuit students with ultimate authority. Some First Nations communities administered the funds, while Indian and Northern Affairs Canada (INAC) directly controlled postsecondary funds in other First Nations communities. First Nations students must apply to their local Band for sponsorship. INAC's criteria for funding include: (a) demonstrated academic ability, (b) letter of acceptance from an accredited

school, (c) enrollment in at least 60% course load, (d) proof of no other funding sources, and (e) submission of transcripts on a regular basis.

Current federal funding covers less than half the costs an ANS will incur in an academic year (Health Canada, 2002).

Although financial "problems are a major barrier to success for many minority students," (Campbell & Davis, 1996, p. 299), the inadequate funding for Aboriginal peoples' postsecondary education has been mired with a long history of institutional racism (Archibald & Urion, 1995; Assembly of Manitoba Chiefs, 1999; Health Canada, 2002; James, 1992; Kirkness, 1999; Walsch, 1995; Yurkovich, 1997). Inadequate funding was the second most frequently cited barrier faced by Aboriginal students and the key concern for ANS (Archibald & Urion, 1995; Health Canada, 2002; Walsch, 1995). Makilauk (2003) identified that insufficient and unstable Band sponsorships contributed to Aboriginal postsecondary students being able to meet basic health, food, and housing needs. "Due to insufficient funds, students reported eating less expensive foods that were often poor quality, excluded healthy essentials such as fruits and vegetables, and included excessive amounts of pasta" (Makilauk, 2003, p. 98). These Aboriginal students experienced the consequences of a poor diet - health problems.

Health Canada (2002) conducted the most thorough examination of available funding to ANS where most ANS lived below the poverty level with dependents. Funding was highly complicated, non-standardized, and grossly inadequate and it came from a variety of bureaucratic sources that were inconsistent across provinces, territories, and institutions. Funding sources included: the First Nations and Inuit Health Branch (FNIB), the DIAND, local Bands, or student loans. For example, all Aboriginal and non-Aboriginal nursing students attending nursing education programs in Canada's territories were entirely supported by the federal government (Bainbridge, 2004). Of

particular note was the finding that Métis nursing students were the most marginalized group (financially), as their Aboriginal ancestry was not included in the DIAND criteria for funding. Scholarships were only available to Métis students during the last 15 months of their nursing program (Health Canada, 2002).

In the following section referred to as “survival,” I describe the existing knowledge about ANS’ ability to cope and succeed despite their struggles.

2.3.2 Survival

Weaver (2001) found that 24% of the ANS identified no struggles in their nursing educational program. Many ANS who identified no struggles pursued their nursing education within an Aboriginal context such as in a tribal college with a large group of ANS and Aboriginal faculty members. Other ANS who identified no struggles claimed that they led their entire lives immersed in the dominant culture (Weaver, 2001).

In terms of recruitment, what factors motivate Aboriginal peoples to enter into nursing education? In terms of retention, what strategies enhance ANS’ success in schools of nursing? Several studies identified why Aboriginal peoples chose nursing as a profession. ANS were motivated to enter nursing education because they wanted to help their peoples (Health Canada, 2002; Walsch, 1995; Yurkovich, 1997)). All located studies identified ANS’ strategies to survive and succeed in a hostile learning environment (Care, 2003; Dickerson, Neary, & Hyche-Johnson, 2000; Health Canada, 2002; Kulig, 1987; Ryan, 1992; Walsch, 1995; Weaver, 2001; Yurkovich, 1997). I refer to the existing knowledge about ANS’ personal and interpersonal strengths as “survival,” which consisted of several factors that enhanced ANS’ success in the school of nursing: (a) previous life experience, (b) perseverance, (c) interpersonal support, (d) playing the game, and (e) desire to make life better for Aboriginal peoples. I describe each factor that contributed to ANS’ ability to endure their nursing programs.

2.3.2.1 Previous life experience

Walsch (1995) identified that previous life or work experience was a contributing factor in the success of ANS, despite a lack of formal academic preparation. Usually, ANS with broad life or work experience in non-academic settings developed skills that compensated for lack of formal education. A description of these skills was lacking. Several studies indicated that some ANS had previous work experience in positions such as hospital volunteers, hospital unit clerks, and emergency medical technicians within the health care system, which motivated these individuals into entering nursing as a profession. These ANS learned that they enjoyed working with people, yet their subordinate positions limited their acquisition of an appropriate knowledge base and ability to provide proper care to Aboriginal peoples and communities (Health Canada, 2002; Walsch, 1995; Yurkovich, 1997).

Previous life or work experience was a positive contributing factor assisting many Non-Aboriginal and Aboriginal postsecondary students through their programs. However, most researchers failed to recognize that ANS required specific previous life experience in terms of practicing the nuances of assessing and coping with individual, group, and institutional racism. Previous life experience negotiating the nuances of individual, group, and institutional racism may better equip Aboriginal students to establish effective coping mechanisms in their postsecondary education (Jackson, Smith & Hill, 2003).

2.3.2.2 Perseverance

Griffiths and Tagliareni (1999) found that minority nursing students participating in their qualitative sample ranked themselves and their drive to succeed as the number one factor contributing to success in their programs. These participants revealed an intense inner drive, unwavering personal commitment and strong self-awareness.

Successful ANS had a strong personal desire and an ability to persist through their programs in order to graduate (Dickerson, Neary, & Hyche-Johnson, 2000; Health Canada, 2002; Jackson, Smith & Hill, 2003; Kulig, 1987; Yurkovich, 1997). ANS identified within themselves their strengths to persist and represent the Aboriginal culture "as fighters" that additionally, created a sense of pride in meeting the challenge (Dickerson, Neary, & Hyche-Johnson, 2000).

2.3.2.3 Interpersonal support

Weaver (2001) found that those ANS who acquired support often located it through formal and informal student groups. Family and peer support were significant indicators of success (Health Canada, 2002; Jackson, Smith & Hill, 2003; Kulig, 1987; Weaver, 2001; Yurkovich, 1997). The literature failed to acknowledge how ANS utilized formal and informal interpersonal support to succeed in their programs. Did peer and family support simply allow ANS to focus on studying or was it used to assist ANS in their ability to cope with their experiences of passive and active forms of racism?

2.3.2.4 Playing the game

As in the case of most postsecondary students, ANS learned how to "play the student nurse game" to overcome hindrances in their educational experiences (Dickerson, Neary, & Hyche-Johnson, 2000; Ryan, 1992). However, "playing the game" was compounded by recurring experiences of being forced to conform to Euro-Canadian viewpoints, communication styles, and behaviors (Jackson, Smith & Hill, 2003). By changing their communication practices to being assertive and conforming to "look people in the eye," ANS acknowledged that they used reflexivity and decided to play the game and conform to faculty expectations rather than receive a failing grade (Dickerson, Neary & Hyche-Johnson, 2000).

Several ANS used isolation from other student groups to create and maintain a focus for success. Some ANS “bottled-up” feelings for the purpose of maintaining the status quo and conforming to the written or unwritten rules of the school. They coped with the dominant group's culture determining what could be given up or retained for the duration of their nursing education and future practice (Yurkovich, 1997).

2.3.2.5 Desire to make life better

In lieu of the historical context of Aboriginal peoples in Canada, ANS had a strong desire to make life better for themselves, their families, and communities. In Yurkovich's study (1997), 14 of the 18 participants repeatedly expressed a need to provide a better life for their children. Despite thoughts of exiting the nursing program, one ANS persisted with her studies because of a personal goal to provide a hopeful future for her children (Health Canada, 2002).

Nine of the 16 ANS in Health Canada's study (2002) indicated their desire to provide care for Aboriginal people and half of the ANS wanted to work as a nurse in an Aboriginal community. These ANS wanted to “give back” to their communities upon completion of their nursing degree. ANS also wished to provide an improvement in the quality of health care to Aboriginal peoples living in northern communities. Some ANS voiced a desire to promote further opportunities for Aboriginal peoples.

2.3.3 What was missing?

In my review of the located literature, I noted a lack of information and research related to problematic intergroup relations and racism's influences on ANS experiences. Research about teaching strategies to promote inclusiveness and anti-racism and different learning styles of ANS was also missing in the nursing literature. Although problematic intergroup relations and racism were virtually ignored in the nursing literature specific to ANS' experiences, I explain how problematic intergroup

relations and racism influenced other Aboriginal students' postsecondary educational experiences. "The fact that racism, discrimination and prejudice in nursing are not well-publicized may contribute to a general complacency and a belief that they simply do not exist" (Health Canada, 2002, p. 87).

2.3.3.1 Intergroup relations

Berkowitz and Barrington (1998) described multicultural education in terms of intergroup relations and identified that terms such as dominant and minority groups are relational. There is a paucity of research that examined linkages between the experiences of ANS in educational settings and the politics of intergroup relations between Non-Aboriginal and Aboriginal peoples in Canada. In relation to the literature appraisal, I identified how the ideology of a culturalist approach dominated intergroup relations between nursing faculty and ANS.

Many researchers and scholars identified the importance of a positive student-teacher relationship, whereby teachers facilitate the empowerment of culturally diverse students (Calliste, 1996; Cannella & Reif, 1994; Crow, 1993; Cummins, 1995; Furuta & Lipson, 1990; Health Canada, 2002; Jackson, Smith & Hill, 2003; Ladson-Billings, 1995; Nairn, Hardy, Parumal, & Williams, 2004; Paterson, Osborne & Gregory, 2004; Rather, 1994). This finding was congruent with studies about ANS' experiences (Dickerson, Neary, & Hyche-Johnson, 2000; Health Canada, 2002; Ryan, 1992). "Native American students came to the program with expectations of a milieu where supportive learning occurs in a nurturing and culturally sensitive environment" (Dickerson, Neary, & Hyche-Johnson, 2000, p. 192). As these ANS became more experienced in their graduate nursing program, they sensed that faculty was more focused on competency-based objectives than the promotion of student-focused teaching (Dickerson, Neary, & Hyche-Johnson, 2000). Unfortunately, several ANS exited their nursing programs, citing

"personal reasons"; however, further investigation established that ANS, who were progressing well in their studies, decided to leave the school because their relationship with nursing faculty was constrained (Health Canada, 2002).

Dickerson and Neary (1999) noted that participating faculty members held preconceptions of the ANS upon entry into the advanced nurse practitioner program. These preconceived notions affected the teaching/learning environment. Rather than conduct a thorough assessment of each individual student, participating faculty members formulated preconceived assumptions such as all ANS would demonstrate a passive style of communication. This finding was congruent with previous research in multicultural education that found that teachers' expectations of students' performances profoundly affected students' outcomes including motivation (Ladson-Billings, 1994).

Native American students' narratives were often focused on faculty-student relationships as important to their experiences, whether as a support or barrier to their success. Factors influencing the faculty-student relationships included student expectations of a nurturing relationship, the reality of the competitive environment, views of faculty feedback as negative criticism, feelings of powerlessness, reticence to seek help because of perceived negative consequences, and perceptions of faculty views (Dickerson, Neary, & Hyche-Johnson, 2000).

Placing issues of respect, relevance, reciprocity, and responsibility in the foreground of discussions about First Nations participation in higher education means that many mainstream students and faculty will have to change the way they relate to Indigenous students. Aboriginal students frequently face a hostile environment in classes since, for them, social and political issues merge with their own identity struggles. Present discussions about First Nations are often contentious because of

unresolved treaties, land claims, and a neoconservative attack on Aboriginal sovereignty (Marker, 2004a, p. 174).

2.3.3.2 Racism

"The common dictionary definition of racism as discrimination against people because of race and the belief that one race is superior hides the central and most destructive element of racism" (St. Denis & Hampton, 2002, p. 11). St. Denis and Hampton (2002) advocated a definition of racism that specifically acknowledged unequal power relations and the history of the relationship between the groups.

In lieu of the relevant implications that racism might have on recruitment and retention of Aboriginal peoples within schools of nursing, I rarely found research specifically interested in its examination (Huff, 1997; Lin, LaCounte & Eder, 1988). Six studies indicated that Aboriginal people experienced racism within postsecondary institutions (Archibald & Urion, 1995; Huff, 1997; Huffman, 1991; Jackson, Smith & Hill, 2003; Lin, LaCounte, & Eder, 1988; Makinaw, 2003) while others in the field of Aboriginal education address the issue (Hornett, 1989; Marker, 1997, 2000, 2004b, 2005; St. Denis & Hampton, 2002). Jackson, Smith and Hill (2003) acknowledged their surprise that American Indian postsecondary students experienced rampant racism in passive and active forms during their tenure and related their naiveté to their own privileged culture. Lack of scholarly attention or complicity to racism in the "academy" must be understood in its long and established national and academic traditions and commitments (Health Canada, 2002; Marker, 2004b; St. Denis & Hampton, 2002; Tullman, 1992). Individual, group, and institutional denial of racism was rampant, yet Canadians continued to choose to condone racism through taken-for-granted societal practices (Ng, 1996 as cited in St. Denis & Hampton, 2002).

Hagey and MacKay (2000) conducted discourse analysis to address the nursing curriculum in regards to antiracism. These researchers found a denial of racism in the nursing profession, despite publicized grievances, law suits, and rallies organized by various professional support groups.

Such denial is reflected in a curriculum that doesn't support either theory about racist phenomena or the open discussion of issues that may come up clinically and has no commitment to ensuring that all graduates have some understanding of these phenomena (Hagey & MacKay, 2000, p. 55).

Essentialist categorizations such as white and other than white were hidden in the perpetuation of inequality. Several theorists and researchers noted that essentialist categorizations needed to be named, reflected upon and bracketed in nursing education's new agenda (Culley, 1997; Hagey & MacKay, 2000; Paterson, Osborne & Gregory, 2004). "The goal of making racism and its effects see-able is to further equity in health professions, in health and in society" (Hagey & MacKay, 2000, p. 55).

Aboriginal peoples' postsecondary learning environment was compromised of inter-related struggles that were over-shadowed by problematic intergroup relations and passive and active forms of racism. Passive racism was experienced by Aboriginal peoples as either being ignored or being singled out (Jackson, Smith, & Hill, 2003). Students viewed their experiences with passive forms of racism as an inherent aspect of their experience that they were required to manage (Jackson, Smith & Hill, 2003). Active racism was typically experienced in discussions about historical or cultural issues.

2.3.3.3 Inclusive and anti-racist teaching strategies

Research in nursing education was lacking in regards to development, implementation, and evaluation of inclusive and anti-racist teaching policies and

strategies. In an appraisal of multicultural and anti-racist teaching in nursing education, several nurse educators claimed that multicultural teaching was necessary to promote an understanding of the different ways that people experience health and illness (Culley, 1996, 1997; Nairn, Hardy, Parumal, & Williams, 2004).

The inclusion of social scientific concepts and analyses into the nurse education curriculum provides an opportunity to discuss the more complex ways in which social relations and social structures impact upon minorities... More importantly perhaps, nurses and nurse educators need to contextualize the health of minority ethnic groups, exploring the dynamics of discriminatory practices which structure many aspects of everyday life (Culley, 1996, p. 569).

Despite recommendations that nurse educators might include a broader social context in studying minority health issues, racism was not necessarily directly examined by this approach. Paterson, Osborne and Gregory (2004) identified that nursing students quickly learned that both nurse educators and staff nurses supported the notion of cultural diversity in principle but their practices often revealed a lesser allegiance. Multicultural teaching strategies needed to be integrated with anti-racist teaching strategies to promote inclusiveness in learning and culturally safe nurse-client interactions (Back, 2004; Browne, Johnson, Bottorff, Grewal, & Hilton, 2002; Culley, 1996, 1997; Nairn et al, 2004; Sharma, 2004). Further research is warranted to study the effectiveness of these integrated teaching strategies on helping all nursing students become more open to diverse world views.

I located one study that specifically examined anti-racism and racism within nursing discourse. Hagey and MacKay (2000) reported findings from a Canadian research initiative that integrated anti-racism in an undergraduate nursing curriculum.

They found that essentialist discourse in nursing curricula perpetuated racism and prevented the ideal of equity. In terms of education of Aboriginal peoples,

A decolonizing pedagogical praxis challenges not only the forms, content, and intent of other pedagogies and their historical antecedents, but also requires a reconceptualization of the social organization of learning in schooling institutions and fundamentally in classrooms. Such a reconceptualization calls for a transformation in the social and intellectual relationships among participants both in schools and in particular communities where schools reside (Tejeda, Espinoza & Gutierrez, 2003, p. 35).

2.4 Chapter summary

The Canadian historical context of Aboriginal peoples and education provided a backdrop to studying ANS' experiences in schools of nursing. The influences of colonial dominance continue today as many Aboriginal peoples struggle to pursue a postsecondary education. By providing a historical overview of Aboriginal peoples in Canadian nursing, I gained insight into the context that might shape ANS' experiences today.

A review of the literature revealed that Aboriginal peoples experienced many barriers in acquiring postsecondary education. Researchers identified several struggles: (a) inadequate high school preparation, (b) lack of support services, (c) rigid institutional policies and procedures, (d) ethnocentrism, (e) and inadequate funding.

What was blatantly missing in the nursing literature was how problematic intergroup relations and racism influenced ANS' experiences and what teaching strategies would facilitate inclusiveness and learning. No specific educational research was located that examined how inclusive and anti-racist teaching shaped ANS' experiences.

They found that essentialist discourse in nursing curricula perpetuated racism and prevented the ideal of equity. In terms of education of Aboriginal peoples,

A decolonizing pedagogical praxis challenges not only the forms, content, and intent of other pedagogies and their historical antecedents, but also requires a reconceptualization of the social organization of learning in schooling institutions and fundamentally in classrooms. Such a reconceptualization calls for a transformation in the social and intellectual relationships among participants both in schools and in particular communities where schools reside (Tejeda, Espinoza & Gutierrez, 2003, p. 35).

2.4 Chapter Summary

The Canadian historical context of Aboriginal peoples and education provided a backdrop to studying ANS' experiences in schools of nursing. The influences of colonial dominance continue today as many Aboriginal peoples struggle to pursue a postsecondary education. By providing a historical overview of Aboriginal peoples in Canadian nursing, I gained insight into the context that might shape ANS' experiences today.

A review of the literature revealed that Aboriginal peoples experienced many barriers in acquiring postsecondary education. Researchers identified several struggles: (a) inadequate high school preparation, (b) lack of support services, (c) rigid institutional policies and procedures, (d) ethnocentrism, (e) and inadequate funding.

What was blatantly missing in the nursing literature was how problematic intergroup relations and racism influenced ANS' experiences and what teaching strategies would facilitate inclusiveness and learning. No specific educational research was located that examined how inclusive and anti-racist teaching shaped ANS' experiences.

A study that examined ANS experiences was greatly needed to unearth how hidden and embedded messages in nursing discourse shaped ANS' experiences. New knowledge about local, translocal, and extra local factors shaping ANS' experiences was urgently required. An exploration of ANS' experiences and how the experiences are shaped can identify factors that enhance or hamper the educational experience. New knowledge can be translated into effective policies and initiatives that enhance ANS' educational experiences thus improving recruitment and retention. Student-teacher relationships, intergroup relations, nursing discourse, and other contextual aspects shaping the construction of Aboriginal peoples' experiences in predominantly white schools of nursing need further examination.

Clearly, with a limited number of ANS to fill vacant nursing positions in Aboriginal communities - a study was required to examine the experiences of ANS in Canadian schools of nursing. Nurse educators and educational administrators required information about:

- similarities/differences in experiences of ANS who originated from an urban versus a northern community,
- how ANS' experiences were determined,
- social relations generating the experience of ANS, and
- ways in which the sociocultural, political, historical, and ideological construction of nursing education shapes ANS' experiences.

3 THEORETICAL AND METHODOLOGICAL PERSPECTIVES

The word itself, 'research', is probably one of the dirtiest words in the indigenous world's vocabulary. When mentioned in many indigenous contexts, it stirs up silence, it conjures up bad memories, it raises a smile that is knowing and distrustful. It is so powerful that indigenous people even write poetry about research. The ways in which scientific research is implicated in the worst excesses of colonialism remains a powerful remembered history for many of the worlds' colonized peoples. It is a history that still offends the deepest sense of our humanity (L. Smith, 1999, p. 1).

3.1 Introduction

In previous chapters, I explained the background to the study and offered a summary of existing knowledge of ANS' experiences in schools of nursing. The chosen theoretical and methodological perspectives guided the ways I viewed ANS' experiences, negotiated access to participants, identified what constitutes data, collected and analyzed the data, and used the research findings. In this chapter, I describe the theoretical perspectives and research methodologies¹⁹ that guided the critical ethnography. I chose specific tenets from various theoretical perspectives and methodologies to broaden the existing knowledge about the everyday world of ANS in that the study would start with the standpoint of ANS, capture the context and discourse that shape ANS' everyday world, and end with the experience of ANS (Campbell, 1998).

Limitations of applying these theoretical and methodological perspectives lie in the risk that I was predisposed to focus on some aspects of the data while ignoring others (Kirkham, 2000; Lather, 1991). To guard against this risk, my goal was to use these perspectives to guide aspects of the critical ethnography in a manner that prevented the theory from becoming the driving force. As stated by Lather (1991),

¹⁹ I use the term, methodologies, to refer to the philosophical, theoretical, and practical basis of conducting research. Research method describes how the researcher implements the study.

Data must be allowed to generate propositions in a dialectical manner that permits use of a priori theoretical frameworks, but which keeps a particular framework from becoming the container into which the data must be poured.

The search is for theory which grows out of context-embedded data, not in a way that automatically rejects a priori theory, but in a way that keeps preconceptions from distorting the logic of evidence (p. 62).

For the purposes of a critical ethnography that examined the everyday world of ANS in Canadian schools of nursing, it was logical to rely on selected tenets from Aboriginal epistemology, Linda Smith's decolonizing methodologies for research and Indigenous peoples (1999), Ramsden's concept of cultural safety (2002), and the social organization of knowledge developed by Dorothy Smith (1986, 1987). Although some theoretical and methodological perspectives were introduced in Chapter One, further clarification is warranted.

While Indigenous peoples conceptualized and developed Aboriginal epistemology, decolonizing methodologies, and cultural safety, the social organization of knowledge was rooted in a feminist critique of mainstream sociology and 'western' science. As experienced by McClelland (2005) in her study of 10 Indigenous nursing students in New Zealand, melding Indigenous viewpoints with feminist theory was somewhat problematic. I dealt with tensions between the theoretical and methodological perspectives by choosing particular tenets from the Indigenous and feminist viewpoints to formulate a theoretical lens to guide the study. Rather than view these tensions as binary or polar opposites, I chose to use different tenets from these theoretical and methodological perspectives to add depth and scope to the study.

For example, in Aboriginal epistemology the oral tradition is the primary route of knowledge translation and acquisition in Indigenous cultures (Battiste, 2002). In contrast, D. Smith's social organization of knowledge posits that texts and discourse mediate the social. In other words, written words govern how people perform their daily activities and work. In this study, I utilized both perspectives in that ANS were asked to tell a story about their experiences in the schools of nursing reflecting somewhat on the oral tradition of knowledge translation in Aboriginal epistemology. I also examined how nursing discourse shaped those experiences reflecting on D. Smith's social organization of knowledge. Please see the table on the following page that depicts tenets I selected from each theoretical and methodological perspective.

Table 1*Commonalities and Unique Features of Theoretical and Methodological Perspectives*

	Aboriginal Epistemology	Decolonizing Methodologies	Cultural Safety	Social Organization of Knowledge
Origin	*Indigenous Peoples' Traditional Education	* Indigenous Peoples' Research	* Health care, Research, & Education for Indigenous & Non-Indigenous peoples	* Feminist critique of sociology and "western science"
Collaborators	Indigenous Peoples	- Indigenous & Non-Indigenous Peoples - Nurses - Educators - Researchers	Indigenous & Non-Indigenous Peoples (Nurses, health care providers, researchers)	- Social activists - Nurses - Educators - Social Workers
Researcher-Participant Relationship	Full Partnership	Full Partnership	*Acknowledges historical context and power relations in relationships; * Reciprocity	*Sharing information for purpose of consciousness-raising
Knowledge Translation and Transference	Oral Tradition * Empirical observations Revelations	Oral Tradition * Empirical observations Revelations	Oral Tradition * Empirical observations Revelations	* Interviews * Reflexive fieldwork * Textual analysis
How theoretical perspective contributes to knowledge development & research	Explains relationship b/w material world, land/nature, and internal self *Broad interpretive lens	* Illuminates historical and sociopolitical context	*Historical context & power relation inherent in all personal relationships; * Illuminates importance of reflection and reflexivity, positionality	*Provided a starting and ending point for research – standpoint of ANS *Explicates how texts organize people's activities

Note. * Tenets used in this study

In the following section, I explain Aboriginal epistemology, L. Smith's decolonizing methodologies for research and Indigenous peoples, and cultural safety followed by my interpretation of D. Smith's social organization of knowledge. I describe how chosen tenets created theoretical and methodological perspectives to study ANS' experiences and the context that shapes those experiences. All theoretical and methodological perspectives embrace the importance of historical influences on current experiences of individuals and the notion of embodied knowledge that reflected the fluidity of tenets guiding the study.

3.2 Aboriginal epistemology

As described in Chapter Two, Aboriginal education, epistemologies and knowledges have been under attack for many years. Aboriginal knowledges are unique to given individuals, families, localities, bands, tribes, and societies (Sefa Dei, Hall, Rosenberg, 2000). Canada's Aboriginal peoples have diverse histories and identities, ranging from hunters and gatherers of the Eastern woodlands, to agriculturalists of the Great Lake region, to game hunters of the prairies, to ocean-travelers of the Pacific coast, to the Inuit of the far North and then the Métis, who emerged historically from interactions between European and Aboriginal peoples (Castellano, 2000). Given this diversity among Aboriginal peoples, an all-encompassing Aboriginal epistemology is not possible (Battiste, 2002). Aboriginal epistemology does not apply to all Aboriginal peoples; rather, my description of Aboriginal epistemology is based upon information gathered from several sources. I describe chosen tenets from Aboriginal epistemology.

Although there is a paucity of writings about Aboriginal epistemology in the Canadian context, there is a measure of consensus on its characteristics and method of transmission.

In Eurocentric thought, epistemology is defined as the theory of knowledge and pedagogy involving the processes by which children come to learn or know. The Aboriginal people of Canada have their own epistemology and pedagogy.

Aboriginal epistemology is found in theories, philosophies, histories, ceremonies, and stories as ways of knowing. Aboriginal pedagogy is found in talking or sharing circles and dialogues, participant observations, experiential learning, modeling, meditation, prayer, ceremonies or story telling as ways of knowing and learning (Battiste, 2002, p. 18).

Aboriginal knowledge is personal, oral, experiential, and holistic. Knowledge is conveyed in oral narratives – sometimes using metaphors (Battiste, 2002; Castellano, 2000). A value shared by many Aboriginal peoples is that their stories, language, customs, songs, dances and epistemology must be preserved because they sustain the life of the individual, family, and communities (Cajete, 1994).

The knowledge valued in aboriginal societies derives from multiple sources, including traditional teachings, empirical observations, and revelation. These categories overlap and interact with one another, but they are useful for examining the contours of aboriginal knowledge (Castellano, 2000, p. 23).

In most Aboriginal societies, Elders were honored as wise and assigned the responsibility of teaching children. Traditional teachings were passed down from generation to generation and tell of the creation of the world. Traditional teachings were

shared by storytelling and the stories record genealogies and ancestral rights to land. This notion of being connected to the land is integral to Aboriginal epistemology.

Empirical knowledge is created from observations of many people over extended time. This knowledge represents "a convergence of perspectives from different vantage points, accumulated over time" (Castellano, 2000, p. 24). I used this tenet to guide the research method in that the research assistant and I made observations in the field and documented our observations in field notes. I also interviewed many people – ANS, Aboriginal nurses, faculty, student support services personnel, and employers – to gather their perspectives of the factors that shaped ANS' experiences.

Similar to the theoretical and methodological perspectives of L. Smith and D. Smith, a key principle of Aboriginal learning is a preference for experiential knowledge (Battiste, 2002). Aboriginal epistemology relies on knowledge that is personal or experiential in nature or in other words, embodied knowledge (Battiste, 2002). In the following quote, the connectedness to the land is linked with inner revelations.

Those who seek to understand the reality of existence and harmony with the environment by turning inward have a different, incorporeal knowledge paradigm that might be termed Aboriginal epistemology... This inner space is that universe of being within each person that is synonymous with the soul, the spirit, the self, or the being (Ermine, 1995, p. 102-3).

Aboriginal knowledges reflect people's experience and relationships that address lived, material, and cosmological concerns (McIsaac, 2000). In the production of these forms of knowledge, traditional values, interests and objectives articulate relationships between land/nature, spirit world, and humans. "The history of indigenous peoples has

shown that to sever these relationships is tantamount to genocide" (McIsaac, 2000, p. 100).

Similar to perspectives of L. Smith, Ramsden, and D. Smith, Aboriginal epistemology relies on the importance of the historical, sociopolitical, and cultural contexts. Hence, I incorporated the historical context of Aboriginal people and education into my theoretical lens. Aboriginal peoples believe that all existence is connected and that the whole context is fundamental to understanding the meaning of many mysteries of the universe (Ermine, 1995).

A distinctive feature of Aboriginal epistemology is its environmental foundation and strong link to the land (Battiste, 2002; Cajete, 1994). This foundation connects an individual, family, or Tribe to their place in the world and establishes their relationship to their land and in turn, the earth in their hearts and minds. The environmental foundation reflects a deeper understanding of the importance of the natural environment as the essential reality or "place of being." Based on the environmental foundation, a mutual relationship or reciprocity was established and perpetuated between people and their environment. The importance of connecting with their "place" is not a romantic notion out of step with current times; it is rather the quintessential ecological mandate (Cajete, 1994). Nature is a sacred reality for Aboriginal peoples. Relationships to the environment formed the basis for Aboriginal expression of traditional education. A direct and abiding understanding of nature's cycles – life, death, struggle, and survival – was integral to the survival of Aboriginal peoples. Aboriginal peoples perceived multiple realities in Nature – that experienced by the five senses was simply one of many realities. Other characteristics of Aboriginal epistemology include:

- Teaching and learning radiate in concentric rings of process and relationship (Fixico, 2003),
- Recognition of personal agency (Fixico, 2003; Cajete, 1994),
- Use of stories as expressed through experience, myth, parables and various forms of metaphor (Battiste, 2002),
- Integration of individuality with communal needs (McIsaac, 2000),
- Learning occurs not only in the mind but also in the body and spirit (Ermine, 1995; McIsaac, 2000).

In Chapter Four, I explain how Aboriginal epistemology provided a broad interpretive lens in the analysis of data. Within the broader interpretive lens of Aboriginal epistemology, I proceed to discuss how tenets within L. Smith's decolonizing methodologies further guided the study in terms of relationships between the researcher and the researched.

3.3 Decolonizing methodologies for research & Indigenous peoples

Linda Tuhiwai Smith (1999), an Indigenous woman from Aotearoa/New Zealand²⁰ developed a research agenda or set of approaches situated within decolonizing politics of the Indigenous peoples' movement²¹. For many Indigenous peoples of Aotearoa/New Zealand, the term 'research' was inextricably linked to European imperialism and colonialism. Decolonization was defined by L. Smith as a

²⁰ The Maori name Aotearoa refers to the nation-state of the country known in today's world as New Zealand. By signifying Aotearoa/New Zealand, I acknowledge the historical context of colonialism situated in this geographical area.

²¹ I would like to thank Dr. Michael Marker for his advice to review Linda Tuhiwai Smith's work prior to conducting the research.

process that engaged with imperialism and colonialism at multiple levels. When describing European imperialism, the term described one or more of these:

1. Economic expansion,
2. Subjugation of 'others' such as Indigenous peoples,
3. An idea or spirit with different forms of realization stemming from the Enlightenment period, and/or
4. A discursive field of knowledge (L. Smith, 1999).

According to L. Smith (1999), "colonialism became imperialism's outpost, the fort and the port of imperial outreach....Research within late-modern and late-colonial continues relentlessly and brings with it a new wave of exploration, discovery, exploitation and appropriation" (p. 23-24).

Decolonizing methodologies expanded the notion of personal agency by focusing on the goal of self-determination of Indigenous peoples. Self-determination was more than a political goal; rather, self-determination became a goal of social justice expressed through and across a wide range of psychological, social, cultural, and economic levels (L. Smith, 1999). Decolonizing methodologies involved transformation, decolonization, healing and mobilization of Indigenous peoples. Although L. Smith (1999) represented the four states of Indigenous peoples and communities as: (1) survival, (2) recovery, (3) development and (4) self-determination, she stipulated that these conditions were not sequential but fluctuated back and forth.

L. Smith's guidelines aimed at respect and protection of the rights, interests, and sensitivities of the researched. These guidelines ensured that research and Indigenous

peoples was more respectful, ethical, empathetic and useful. Researcher responsibilities included:

- Aroha ki te tangata (a respect for people).
- Kanohi kitea (the seen face, that is present yourself to people face to face).
- Titiro, whakarongo ... koreto (look, listen ...speak).
- Manaaki ki te tangata (share and host people, be generous).
- Kia tupato (be cautious).
- Kaua e takahia te mana o te tangata (do not trample over the *mana* of people).
- Kaua e mahaki (don't flaunt your knowledge) (L. Smith, 1999, p. 120).

From the perspectives of Indigenous peoples, ethical codes of conduct served partly the same purpose as the protocols that governed their relationships with other people and with the environment and land with 'respect' as a key value (L. Smith, 1999). Specific research methods stemming from decolonizing methodologies are articulated in the following chapter. Tenets from L. Smith's decolonizing methodologies for research and Indigenous peoples provided me with key values to conduct the research and analyze the data. In the following section, I proceed to explain how tenets from cultural safety were used to promote reflection and reflexivity in the study in that cultural safety ensured that I acknowledge the presence of power relations and the influences of positionality.

3.4 Cultural safety

Cultural safety, sometimes referred to as Kawa Whakaruruhau in the Indigenous²² context of Aotearoa/New Zealand, is defined as:

The effective nursing or midwifery practice of a person or family from another culture, and is determined by that person or family. Culture includes, but is not restricted to age or generation; gender; sexual orientation; occupation and socioeconomic status; ethnic origin or migrant experience; religious or spiritual belief and disability (Nursing Council of New Zealand, 2002, p. 7 as cited in Richardson, 2004, p. 35).

During the 1980s in Aotearoa/New Zealand, several Indigenous nursing students identified deleterious effects of the Eurocentric nursing education system on Indigenous nursing students as well as the negative effects of an ethnocentric health care system on the overall health of the Indigenous population (Coup, 1996). Historically, colonizing processes within health care and nursing education disregarded the illness and health beliefs of the Indigenous peoples and privileged those of the dominant 'white' culture in the construction of Aotearora/New Zealand's health care system (Smye & Browne, 2002).

In 1990, Irihapeti Ramsden, an Indigenous nursing student and the principal architect of cultural safety, articulated the need for nurses to provide culturally safe care to Indigenous peoples of Aotearoa/New Zealand in recognition of the historical practices within a health care system that failed to recognize Indigenous peoples as a distinct population group (Coup, 1996; Kearns & Dyck, 1996; Ramsden, 2002). Ramsden built

²² I use the term, Indigenous, rather than Maori based upon Linda Tuhiwai Smith's observation that Maori is a label that defines the colonial relationship between the Maori and the Pakeha, the non-Indigenous settlers (1999).

her ideas about cultural safety using the work of Paolo Friere, recognizing the potential for educators to perpetuate oppression (Kearns & Dyck, 1996). "The concept of cultural safety provides for the formal recognition of power relations within health care (and particularly nursing) interactions" (Richardson, 2004, p. 35). The main objective of cultural safety was to prevent actions that prompted its inception: disenfranchisement of Indigenous peoples and lack of understanding about the Indigenous models of health and illness (Dyck & Kearns, 1995).

Ramsden (1993, 1995, 2000, 2002) worked with Indigenous leaders to develop a model for a negotiated and equal partnership between Indigenous nursing students and nurse educators in Aotearoa/New Zealand's nursing education system. Also in consultation with Indigenous peoples, Ramsden conceptualized a model to address the issue of cultural safety when practicing nursing in a bicultural context, which became integral to the nursing curricula (Browne, 2003; Kearns & Dyck, 1996; Ramsden, 2002). "Cultural safety is, therefore, not about 'cultural practises'; rather, it involves the recognition of the social, economic and political position of certain groups within society, such as the Maori people in New Zealand or aboriginal people in Canada" (Smye & Browne, 2002, p. 46).

Starting in 1991, the Nursing Council in New Zealand established a requirement that 20% of the national examination for nursing registration should focus on cultural safety. In other words, nursing graduates were required to demonstrate that they were not only safe academically, clinically, and legally, but that they were also culturally safe in their interactions with Indigenous peoples (Dyck & Kearns, 1995; Ramsden & Page, 1993). According to Kearns and Dyck,

The objectives of the Nursing Council guidelines clearly indicate that what is required of students is more than passing familiarity with customs or 'differences.' Rather nurses and midwives are to examine their own cultural realities and the attitudes they bring to their practices; they must be open-minded and flexible in their attitudes toward people from differing cultures to whom they offer and deliver service; and they need to be cognizant of the location of health problems within historical and social processes (1996, p. 372).

Nurses, who use cultural safety as a standard of practice, recognize that there is more diversity among Indigenous groups. As well, these nurses acknowledge the position of certain groups such as Indigenous groups within a particular society. "It is how this group is perceived and treated that is relevant rather than the different things its members think or do" (Polaschek, 1998, p. 452).

As a researcher, I acknowledged that Aboriginal nursing students would have an array of experiences in their home communities and in the schools of nursing. I ensured that I was aware of the position of Aboriginal groups within Canada by gaining knowledge of the history of Aboriginal peoples and education and by following the media (radio, television, newspapers) with its discourse about Indian-white relations.

Nurses, who use cultural safety as a concept, recognize that no health care interaction including interactions between nursing students and nurse educators is ever simply objective. Nurses recognize that they always operate from their own cultural beliefs and mores that influence how they interact with Indigenous clients and/or Indigenous nursing students. "If mitigation of cultural risk is important in health practice it can also be argued that it is an important, indeed, a necessary, requirement of the

research enterprise" (Lynam & Young, 2000), p. 8). As a researcher, using cultural safety as a concept, I recognized that no interaction between participants and me was ever simply objective. I recognized that I operated from my own Euro-Canadian cultural beliefs and mores that influenced my interactions with participants.

Cultural safety was a key theoretical and methodological perspective in that it facilitated a more reflexive, critical understanding of this research (Richardson, 2004). Nurses' attitudes and values inevitably evolved from their social and political contexts. As such, nurses' attitudes and values are somewhat reflective of the wider community (Richardson, 2004). By incorporating tenets of cultural safety into my theoretical and methodological perspectives, the research assistant and I were constantly poised to be reflexive in regards to our positionality and standpoint. The research assistant was an urban Aboriginal with an undergraduate nursing degree. Her ancestors were from a northern First Nations community and she shared this information about her origins with participants. As a middle-aged, middle class, white researcher, I utilized the relational tenet of cultural safety to challenge my openness to others' viewpoints and my sensitivity to others' standpoints.

In addition to being viewed as a process, cultural safety has been regarded as an interpretive lens (Anderson, Perry, Blue, Browne, Henderson, Basu Khan, Reimer Kirkham, Lynam, Semeniuk, & Smye, 2003; Browne, 2003; Richardson, 2004; Smye and Browne, 2002). Cultural safety prompted nurses to ask themselves a series of questions to unmask the ways in which policies, research, education and practices may perpetuate neocolonial approaches to the health care and education of Indigenous peoples. Although cultural safety is applicable to health care services, education,

research, and policy across diverse cultural groups, Smye and Browne (2002) believed that cultural safety was particularly useful when examining Aboriginal health. As cultural safety initially was poised to address and promote inequities in the nursing education of Indigenous students, I view cultural safety as being particularly applicable to nursing education involving Canada's Aboriginal peoples, given the historical context of Aboriginal health and education. Using this tenet of cultural safety, questions were facilitated to unmask the ways in which the school's policies were developed and sustained.

To be compatible with principles of cultural safety a number of points needed consideration. These points included: the nature of the research question and knowledge it produced, the relationship between the researcher and the 'researched', how culture was viewed and its influences appraised. The research question must be designed to produce knowledge that will be of use to the population of concern" (Lynam & Young, 2000, p. 8).

For the purposes of this study, I used tenets of cultural safety to guide specific research strategies. Cultural safety ensured that I engaged in praxis²³ while conducting the study. These strategies will be discussed in depth in Chapter Four. I proceed to explain how tenets from D. Smith's social organization of knowledge were used to provide a starting and ending point for the research.

3.5 The social organization of knowledge

Dorothy Smith initially developed a feminist sociology from the standpoint of women as a critique of mainstream North American sociology (Campbell & Manicom,

²³ "The advent of the concept of 'praxis' within nursing signified that nursing scholarship had taken a turn beyond preparation of scientists, theoreticians, and practitioners, toward preparation of those who are capable of handling the implications of their ideas within each of these realms" (Thorne, 1997, p. xi).

1995). "Established sociology has objectified a consciousness of society and social relations that "knows" them from the standpoint of their ruling and from the standpoint of men who do that ruling" (D. Smith, 1987, p. 2).

Smith's sociology for women endured a wider application in that it served to guide research studies of other groups of marginalized people and their social processes, not solely women (DeVault & McCoy, 2001; D. Smith, 1987). This theoretical and methodological perspective evolved over time and its nomenclature changed to the social organization of knowledge (Campbell & Manicom, 1995). Many researchers relied upon the social organization of knowledge in studies about various social processes such as sexuality (Khayatt, 1995; Kinsman, 1995, 2002), health care including nursing practice (Browne, 2003; Campbell, 2000; Kirkham, 2000; Rankin, 2002; Townsend, 1996), education including nursing education (Campbell, 1995; Jackson, 1995; Paterson, Osborne, & Gregory, 2004), other social services (DeMontigny, 1995, 2002; O'Neill, 1998, 2002; Pence, 2002), and political and social activism (G. Smith, 1995).

Dorothy Smith conceptualized "reality" as the everyday world, which was subjective, co-constructed, and influenced by its historical and sociopolitical context (1986, 1987). The aim of the social organization of knowledge was to examine the problematic defined as:

properties of the social organization of the everyday world in contemporary society, which is only partially discoverable within its scope and the scope of the individual's daily activities. Its local organization is determined by the social relations of an immensely complex division of labour knitting local lives and local

settings to national and international social, economic, and political processes (D. Smith, 1986, p. 6-7).

The social organization of knowledge involved an ontology that viewed "the social" as the way to shape or rule people's work or activities (DeVault & McCoy, 2001). Other social theorists also adopted this ontology - phenomenology, symbolic interaction, and ethnomethodology (DeVault & McCoy, 2001).

Smith expands this through the concept of social relations, which ...refers to the coordinating of people's activities on a large scale, as this occurs in and across multiple sites, involving the activities of people who are not known to each other and who do not meet face-to-face (DeVault & McCoy, 2001, p. 752).

"The fulcrum of the social organization of knowledge is the standpoint of the subject, preserving the presence of subjects as knowers and as actors" (D. Smith, 1987, p. 105). Using this tenet from the social organization of knowledge, I was provided with a starting point for the research – exploring the experiences of ANS from the standpoint of the ANS. I needed to acquire rich data from ANS about their educational experiences.

Because the social organization of knowledge provided a theorized basis for critically examining textually mediated discourses, researchers then explored how ideas and social forms of consciousness might originate outside of participants' experience. D. Smith (1987) viewed that how people think about and express themselves arises out of their everyday social relations. Ideas and images produced by the dominant social group penetrate the social consciousness of a society and may effectively silence expression of the actual reality that people experience. This ideology offers an analysis

that shows how a contradiction can arise between the world as it is known directly in experience and as it is shared with others. The ideas and images fabricated externally to the everyday world may dictate a means to think and envision it (D. Smith, 1987). Using this tenet from the social organization of knowledge, I proceeded to examine how nursing discourse shaped the everyday experiences of ANS.

It is necessary to briefly clarify key concepts within Dorothy Smith's social organization of knowledge. In this section, I provide definitions to important terms that interplay throughout this theoretical and methodological perspective.

3.5.1 Social organization

Similar to tenets within Aboriginal epistemology that views the world as a social world (Cajete, 1994), D. Smith articulated that the only way a person can be in the world is as a social being. The "social arises in people's activities and through the ongoing and purposeful concerting and coordinating of those activities" (Campbell & Gregor, 2002, p. 27). The depiction of social life is that it is well organized. People's decisions and actions are somehow coordinated with outside events and this "concert" stems from social relations. "It is the interplay of social relations, of people's ordinary activities being concerted and coordinated purposefully, that constitutes 'social organization' " (Campbell & Gregor, 2002, p. 27).

3.5.2 Social relations

Social relations are not simply relationships between people such as relationships between students and teachers. Social relations are actual practices and actions through which people's lives are socially organized. "Different individuals, different individual courses of action, enter into relations through which they are

organized vis-à-vis one another" (D. Smith, 1999, p. 150). Social relations are courses of action that take place across different social settings. People participate in social relations, often without knowing that they are, as they act with competence and knowledge to concert and coordinate their own actions with particular standards, expectations, or rules. "Smith saw the benefits of being able to make visible as *social relations* the complex practices that coordinate people's actions across separations of time and space, often without their conscious knowledge" (Campbell & Gregor, 2002, p. 31).

3.5.3 Ruling relations

"Ruling relations" denotes more than an imposition of rules. In comparison with L. Smith's decolonizing methodologies for research and Indigenous peoples and cultural safety in their acknowledgement of power relations and positionality, "ruling" reflects the socially-organized exercise of power that shapes people's activities. In her depiction of ruling relations, D. Smith (1987) relied upon the premise that people actually know how to work alongside particular standards, expectations, rules and act accordingly.

According to D. Smith, ruling relations are text-based (1999). "Ruling takes place when the interests of those who rule dominate the actions of those in local settings" (Campbell & Gregor, 2002, p. 36).

3.5.4 Texts

According to D. Smith (1999), printed and electronic texts are essential to the social organization of knowledge. With the proliferation of texts of all kinds, text-based communication interplays within social relations. People, particularly in occupations in the human services such as nursing and nursing education, conduct their daily

activities, work, and studies by following texts, forms, and reports. Texts are important tools and "taken-for-granted-instruments for the work" (Campbell & Gregor, 2002, p. 33). D. Smith poses to understand how texts are components within social relations. Texts are viewed as "being like speakers in a conversation; that is, though deprived of the possibility of hearing and responding to us, as nonetheless present and active in 'speaking' to us as our reading activates them" (D. Smith, 1999, p. 135). In contemporary societies such as the Canadian society, texts are commonly involved in the translocal and extralocal processes of administration and governance that constitute ruling relations (D. Smith, 1999).

3.5.5 Experience

Similar to Aboriginal epistemology and L. Smith's decolonizing methodologies for research and Indigenous peoples, experience has both conceptual and methodological centrality. Experience "is the ground zero of the analysis. The analysis begins in the participants' experience and returns to it, having explicated how the experience came to happen as it did" (Campbell, 1998, p. 56). "The conceptual importance of experience lies within the ability to provide people with a "real-life context" to reflect upon one's activities and their effects on other peoples' lives" (Campbell & Manicom, 1995, p. 7). Campbell and Gregor (2002) referred to embodied knowing as a crucial theoretical point in the social organization of knowledge. Human beings know through having a body and having a consciousness (D. Smith, 1990).

The methodological importance of experience is that it provided me as the researcher with a standpoint, a place to start and end the inquiry, to demonstrate its purpose. "Beginning in experience helps the researcher identify 'whose side she is on,'

while constructing an account that can be trusted" (Campbell & Manicom, 1995, p. 7). Participants are viewed as the "knowers" and the research assistant and I chose to think of the ANS as the experts in knowing their experience. This approach kept the ANS at the centre of the analysis. By maintaining a standpoint in the ANS's everyday world, I analyzed how the ANS' world was socially organized. By working closely with the research assistant and the Advisory Council, I focused on the standpoint of the ANS. I then proceeded to examine the "discourse as the organizer of experience while maintaining one's analytic interest in the subject, the knower" (Campbell & Gregor, 2002, p. 40). I explored how nursing discourse shaped the ANS' experience.

3.6 Chapter summary

In this chapter, I explained chosen tenets from Aboriginal epistemology, L. Smith's decolonizing methodologies of research with Indigenous peoples, Ramsden's cultural safety, and D. Smith's social organization of knowledge that influenced the ways that I studied ANS' everyday experience and the ways in which the social, historical, ideological, and political construction of nursing education shaped ANS' experiences. These theoretical and methodological perspectives provided me with a panoramic lens to view social structures and power issues within schools of nursing. Social structures and ruling relations required examinations within their social, historical, ideological, and political contexts.

These theoretical and methodological perspectives provided a broadened scope and increased depth to guide me in the examination of how the historical, sociopolitical, cultural, and ideological context shaped ANS' experiences in a predominantly Euro-

Canadian educational setting (Townsend, 1996). D. Smith's social organization of knowledge provided a starting point for the research – the experience of the ANS.

In Chapter Four, I outline the research strategies and explain how the theoretical and methodological frameworks were used to guide my approach. By engaging critically with the theoretical and methodological perspectives and being conscientious of reflection and reflexivity specified by cultural safety, I promoted a study whereby the theory grows out of the context-embedded data – not data being categorized by theory.

4 METHOD OF INQUIRY

There is no "one way" to conduct an IE [institutional ethnography] investigation; rather, there is an analytic project that can be realized in diverse ways. IE investigations are rarely planned out fully in advance. Instead, the process of inquiry is rather like grabbing a ball of string, finding a thread, and then pulling it out; that is why it is difficult to specify in advance exactly what the research will consist of. IE researchers know what they want to explain, but only step by step can they discover whom they need to interview or what texts or discourses they need to examine (DeVault & McCoy, 2001, p. 755).

4.1 Introduction

Given the background to this study, current knowledge about ANS' experiences, and the theoretical and methodological perspectives guiding this study, it was logical for me to choose a critical ethnography as a method of inquiry. I delineate how I incorporated specific aspects of Aboriginal epistemology, decolonizing methodologies for research and Indigenous peoples, cultural safety, and the social organization of knowledge into the method of inquiry. In this chapter, I describe the research design and its implementation to study the experience of ANS and the context that shaped it. I follow with a discussion of how scientific and ethical quality was established. Finally, I conclude the chapter with a brief summary of the method of inquiry.

In choosing the design, I asked myself these questions: (1) How does the design connect to the theoretical and methodological perspectives – how do the empirical materials inform and interact with the paradigm? (2²⁴) Who or what will be studied? (3) What strategies can best address the research questions? (4) What strategies of inquiry will be used? in addition (5) What methods will be used for collecting and analyzing

²⁴ I use the word, paradigm, to designate worldview. A paradigm consists of several elements: epistemology, ontology, methodology, and axiology. Guba and Lincoln (1994) delineated the major paradigms and perspectives as positivism, postpositivism, constructivism, and critical theory (where I locate feminisms).

empirical materials? (Denzin & Lincoln, 1998). In the following section about the method of inquiry, I address the answers to these aforementioned questions.

4.2 Critical ethnography/Institutional ethnography

In 1986, Dorothy Smith proposed a research strategy for studying the social organization of knowledge, aiming to explicate the actual social processes and practices that organize people's everyday/everynight lives (D. Smith, 1986). In her research strategy, researchers understand that everyday life is "*constituted by people whose activities are coordinated in specific ways*" (Campbell & Gregor, 2002, p. 69). For that reason, data that captured rich details and the contextual aspects of ANS' experiences was necessary for the study. Data included interviews and fieldwork about (a) the everyday lives of ANS from the standpoint of ANS, (b) faculty's experiences teaching ANS, (c) the context shaping ANS' experiences, along with (b) a collection of texts, such as the schools' policies and procedures, nursing textbooks and course syllabus, websites among others to map how the everyday world of ANS was organized by people in an extralocal setting (Campbell & Gregor, 2002).

Institutional ethnographers explore a particular problematic in explicating what is happening in a local setting, as people know and live it there. The notion of explication is important – it is the analytic core of the research process in institutional ethnography. We say that researchers begin in the everyday world, collect data about it, and proceed to explicate a problematic by going beyond what can be known in any local setting. There are really two levels of data and data collection involved in explication. Data collection has to expand beyond what people in the local setting know and do...To understand the workings of any

setting involves learning how people, seemingly positioned outside the setting, are nevertheless active inside it (Campbell & Gregor, 2002, p. 59-60).

For various personal and professional reasons, the study actually evolved over time. I began conducting the research in 2002-3. After many hours of fieldwork and difficulty recruiting ANS, I took a leave of absence from the doctoral program to grieve a significant loss in my family. During this time away from the doctoral dissertation, I reflected upon the fieldwork and developed revisions to the research design. I re-entered the doctoral program in 2004-5 and resumed the fieldwork in the same research settings with revisions to recruitment and design.

Reflexivity and discussions with members of the Advisory Council and my thesis committee were crucial in that these dialogues helped me to process the need to hire a research assistant (RA) using these criteria: (a) Aboriginal ancestry; (b) experience as a student nurse, (c) good listening skills, and (d) experience in health related research. In July, 2004, I hired Ms. Ardelle Kipling, RN, BN, to work with me to recruit ANS, conduct interviews with ANS, conduct fieldwork in the schools of nursing, analyze several transcripts of interviews with ANS, and co-present findings of the research via paper presentations and publications.

I acquainted the RA with the study by providing her with a copy of my application for ethical approval. I provided the RA with the interview guide. We met to discuss interviewing techniques and revised the interview guide to emulate the RA's voice, not mine. The theoretical and methodological perspectives guided the interview process in that I wanted to gather data experientially, in context, and in relationships characterized by empathy and egalitarianism (Heyl, 2001).

Incorporating aspects from decolonizing methodologies and cultural safety, the RA and I worked as a team in informal and formal meetings with ANS and faculty in the research settings and with Aboriginal nurses in the wider nursing community. We held informal meetings with the president of the Aboriginal Nurses Association of Canada to discuss the experiences of ANS and our plan to disseminate the study's findings.

A nursing faculty member contacted me about a symposium about Aboriginal Nursing Education chaired by the ANAC in Ottawa, Ontario, Canada and invited me to attend based on a suggestion by an administrator. At the symposium, I networked with Aboriginal nurses and other educators who recognized the influences of colonialism and internal neo-colonialism on nursing education of Aboriginal peoples in Canada.

Another strategy to connect with ANS and establish the notions of trust and respect included holding one-hour informal information sessions at the research sites about the study. The other purpose of these sessions was to recruit potential participating ANS. I held formal meetings with the RA and chief administrators of the schools of nursing to establish rapport and ensure administrative support for access to the institutions (Campbell & Gregor, 2002).

In the following sections, I describe the implementation of studying the local setting of the two schools of nursing as well as the translocal and extralocal influences using specific aspects from the theoretical and methodological perspectives categorized by important components of qualitative methods:

- Sampling including settings and sources of information such as individuals and texts,
- Relationship between the researcher and those studied,

- Data collection, and
- Data analysis.

4.2.1 Sampling

Sampling includes what times, settings, or individuals are selected to observe or interview, and what other sources of data are utilized. "Purposeful/theoretical sampling attempts to select research participants according to criteria determined by the research purpose but also guided by the unfolding theorizing" (Tuckett, 2004, p. 53). Within my explanation of sampling, I describe these important components: (a) research settings, (b) gaining and sustaining access to the settings, and (c) description of the sample.

4.2.1.1 Research settings

I used purposeful/theoretical sampling in that I deliberately selected two Canadian schools of nursing²⁵ as the research sites based upon criteria. I sought schools of nursing that were actively recruiting Aboriginal peoples into their programs. It would have been illogical to conduct the study in a school of nursing that lacked ANS. At one school of nursing, approximately 2% of the student body identified themselves as being Aboriginal, while at the second school, 11% of the student population was comprised of Aboriginal students.

Travel costs and ethical considerations influenced my choice of settings. For example, it would be cost prohibitive to travel 2000 miles away to conduct the research in Halifax, Nova Scotia. I also limited the research settings to the classroom and laboratory settings within the schools because the inclusion of clinical practice sites

²⁵ Schools of nursing located within universities are referred to as either faculties or schools depending upon specific criteria. Schools of nursing located within colleges are known as schools. To protect the identity of participants, I refer to the research sites as schools of nursing.

would require acquisition of informed consents from patients, family members, nurses, and other health care professionals and that process would have been overly daunting.

My standpoint provided me with insight into the diversity of Canada's Aboriginal population, Aboriginal health and education issues, and the current shortage of nurses in Aboriginal communities.

You begin your research training from your own place with particular background experiences and expectations...Rather than treating a knower's location as a problem of bias, we believe it reveals something about whose interests are served. And that is an issue of power (Campbell & Gregor, 2002, p. 14-15).

I was aware of the invisibility of Aboriginal issues within the media and urban culture.

My past experience as a nurse educator provided me with some knowledge of the scope of the curricula and pedagogy offered to ANS. As explained in Chapter One, my experience led me to question how ANS' experiences were organized – by whom and by what.

One school of nursing was located in a modern sterile building with a spacious lobby. Classrooms, practice laboratories and faculty offices were typically located within this one building. The other school of nursing was situated in an older cramped building that emulated a high school environment with some faculty offices and practice laboratories located in other areas of the campus. Aboriginal Student Resources were located at both educational institutions; these resources were located within walking distance from the schools of nursing.

During 2002-3, fieldwork at the first school of nursing was comprised of 150 hours in classrooms and laboratory practice sessions with participating ANS and faculty.

The numbers of students attending each classroom or laboratory session varied from five to a 150 students. During 2004-5, the RA and I conducted another 50 hours of fieldwork at both research sites. During 2002-3, I conducted one interview outdoors on a park bench and another one in a coffee shop because I lacked an on-site interview room. In 2004-5, the RA and I negotiated access to interview rooms at both sites.

4.2.1.2 Gaining & sustaining access

Gaining and sustaining access to the research setting and participants was a crucial component in this study. I discuss gaining and sustaining access to the research setting in terms of gaining and sustaining access to the: (a) advisory council, (b) setting, (c) ANS, (d) nursing faculty, and (e) key informants.

4.2.1.2.1 Advisory council

Because of my standpoint as a Non-Aboriginal nurse with experience as a nurse educator, the chair of my thesis committee and I decided that it would be highly beneficial for me to recruit several Aboriginal nurses for advisement. The advisory council was comprised of five Aboriginal nurses who volunteered to participate. The purpose of the advisory council was to provide me with expertise about ANS' experiences and advice if I came upon issues in conducting research with Aboriginal peoples.

Prior to recruiting ANS, faculty, and key informants, I approached an executive member of the Aboriginal Nurses Association of Canada to contact Aboriginal nurses of that person's choice to ask them if they would be available and interested in providing me with advice about conducting the study. The executive member contacted several Aboriginal nurses (I was unaware of the names of the individuals at that time) who

agreed to become members of the advisory council. One Aboriginal nurse was referred to me by a member of my thesis committee. I identified another Aboriginal nurse during an annual meeting for the Aboriginal Nurses Association of Canada. From these sources, I successfully recruited five Aboriginal nurses to assume the roles of advisory council members.

I consulted the advisory council several times during data collection and analysis. The advisory council provided me with insight into problems with recruitment. I also shared preliminary findings with the advisory council members to see if the findings resonated with their experiences as student nurses in Canada. Two advisory council members also volunteered to participate in a one-hour audio-taped interview with me to share their experiences as ANS. These nurses' stories provided me with a historical perspective about ANS' experiences in Canadian schools of nursing as their experiences occurred up to 20 years ago.

Upon completion of the thesis, advisory council members will receive a "thank you" card for their time and effort in offering me their insights into ANS' experiences and conducting research with ANS. I will include a copy of the executive summary of the study.

4.2.1.2.2 Research setting

With 30 years experience in nursing, I was familiar with some health care and educational administrators and nursing faculty. This prior contact eased the negotiation of my entry into both research settings. "There are people to meet and talk to about the research plan. There are formal relations to be negotiated consisting of issues of access – permissions, approvals, ethical reviews, and organizational and individual

consents" (Campbell & Gregor, 2002, p. 61). I sent chief educational administrators²⁶ at two Canadian schools of nursing a letter to inform them of the proposed research study and to ask them for permission to conduct the study at their particular school of nursing. Chief administrators responded with a letter informing me that upon ethical approval, they would provide me with permission to access the schools of nursing. Ethical approval was acquired from Research Ethics Boards at the University of British Columbia and the two research sites.

Upon acquisition of ethical approval, I contacted the chief administrator at the school of nursing that I will refer to as research site #1 and I met with the administrator to provide more information about the study. At this time, I decided to focus recruitment and data collection at site #1 due to a pervasive feeling of being overwhelmed by the process of recruitment and data collection at more than one research site.

Prior to revisions to the research design in 2004-5, I held informal and formal meetings with chief administrators to inform them of the upcoming "restart" to my doctoral dissertation. One administrator suggested that I contact a health care administrator about recruitment strategies in that a health care agency had recently recruited several ANS to a meeting at the school of nursing. I contacted the administrator at the health care agency, who provided me with several useful suggestions based on their recruitment efforts. The chief administrators offered other suggestions that supported other strategies including: (a) hiring an Aboriginal research

²⁶ In Canada, chief administrators of faculties of nursing are known as deans and chief administrators of schools of nursing are referred to as directors. To protect the identities of participants, I will simply designate chief administrators to describe people deemed to be leaders and primary decision-makers within the designated institutions.

assistant (RA), and (b) providing ANS students with an honorarium for participating in the interview process.

I submitted applications for ethical approval of necessary revisions to the research design and requests for time extensions due to my leave of absence from the doctoral program. Concomitantly, I sent letters to the chief educational administrators requesting their continued support for the research (see Appendix A). Upon acquisition of ethical approval, I contacted chief administrators from the research sites and arranged a meeting to: reintroduce myself and the research topic, introduce the RA, discuss recruitment strategies and request resources such as an interview room.

Chief administrators were informed that data collection was completed. Upon completion of the thesis, I will provide chief administrators with an executive summary of the study focusing on findings and recommendations. At each research site, the RA and I will facilitate a seminar to share findings with the nursing faculty and devise innovative and collaborative teaching strategies and recommendations for policy development.

4.2.1.2.3 Aboriginal nursing students

Since the study focused on the experiences of ANS, I relied on the underlying tenets from D. Smith's social organization of knowledge and its related method of inquiry, institutional ethnography (IE), to frame the sampling strategies. To recruit ANS in 2002-3, a staff member of the schools posted advertisements for participants on bulletin boards located in various hallways of the building. I sent e-mail letters to course leaders, asking them to provide me with permission to visit their classrooms and spend five to ten minutes introducing myself, the study, and requesting that students who

identify themselves as being of First Nations ancestry²⁷ volunteer to participate. At this time, I did not provide participating ANS with an honorarium.

To recruit ANS in 2004-5, the RA and I used letters, posters, informal information sessions, and classroom visits by the RA (as per nursing faculty members' choice – see Appendix B for e-mail to faculty). Staff members from the schools posted advertisements for participants on bulletin boards, beside elevators, and outside faculty members' offices at the beginning of the fall session in 2004. These posters (see Appendix C) served to:

1. Invite ANS to attend a one-hour informal information session with refreshments offered,
2. Invite ANS to participate in a one hour audio-taped interview,
3. Provide information that ANS who participated in the interview would receive a \$30.00 honorarium , and
4. Provide the RA's contact telephone number and e-mail address.

I provided both sites with form letters written and signed by the RA, inviting ANS to participate (see Appendix D). The letters reiterated information from the posters and added information about the purpose, benefits, and risk of participating in the study. Chief administrators or designates were asked to X-press Post these letters to students who had identified themselves to the postsecondary institutions as having Aboriginal²⁸ ancestry.

²⁷ This nomenclature proved to be problematic in that students perceived that the study's inclusion criterion was only students who identified themselves as Status Indians or Treaty Indians.

²⁸ In an interview with a key stakeholder, I acquired information about post-secondary educational institutions and their record keeping. In 2003, post-secondary educational institutions in this province began to keep records about the numbers of students who were Aboriginal. Upon registration, students were asked to self identify. It is recognized that many Aboriginal students will not self identify based upon past and present negative experiences if they are labeled as being Aboriginal. Although these records

Staff members at the first school of nursing informed me that it was difficult for them to access the list of Aboriginal nursing students' names and mailing addresses, so they elected to provide these letters to a student counselor who distributed them to ANS. I was becoming aware of the fact that "organizations typically exercise caution about disclosing organizational information" (Campbell & Gregor, 2002, p. 63), especially when the information was sensitive and private in nature, although I had constructed an ethically approved process whereby I was unaware of students' names and addresses. Twelve ANS received the letter via hand delivery from an Aboriginal student services support person.

Following proof, in the form of a facsimiled copy, that I acquired ethical approval from school #2, a designated faculty member mailed the letters via Xpress Post to ANS from the educational facility's list of self-identified ANS. As well, nursing faculty chose to introduce and discuss the posters in their classes.

"Besides convincing organizational leaders to cooperate with the research, researchers must interest ordinary members in acting as informants" (Campbell & Gregor, 2002, p. 64). The RA and I held a 60-minute informal information session for ANS in rooms at both research sites. Given our knowledge of the limited financial resources available to ANS and following L. Smith's recommendation to be generous (1999), we provided more than ample refreshments for interested ANS. The RA and I encouraged ANS to take refreshments home to their families that were gratefully accepted. Information sessions to students were informal. To begin the information sessions, I briefly introduced myself and provided information about the background and

are an inaccurate reflection of the actual number of Aboriginal peoples enrolled in post-secondary education, a list of Aboriginal students exists.

nature of the study. I explained why I was interested in learning about ANS' experience. The RA then introduced herself by including information about her ancestral roots and the northern Aboriginal "places" or communities where her family originated. The RA then provided information about the interview process and discussed how we would protect students' identities. Interested students were asked to leave their names and telephone numbers with the RA.

A total of 24 ANS attended the information sessions. Attendees were encouraged to "spread the word" that we wanted to hear the stories from all ANS. The RA then contacted ANS who left their names and numbers with her at the information session. The RA also contacted ANS who e-mailed or telephoned her indicating interest in the study or interest in participating because of the letter, poster, or word of mouth.

Access to participating ANS was sustained through mutual respect during the interview process. Reciprocity was attained as ANS were provided with an honorarium for their time. As well, the RA informed students that they would be provided with a summary of the study's findings upon completion of the thesis. Prior to submitting the first paper presentation, the RA and I decided that we needed further permission from the ANS to use specific quotes. The RA telephoned the corresponding participants and asked for permission to use their quotes. The RA explained the context in which their quote would be used to illustrate points. Each student permitted us to use their quote and informed the RA that they wanted others to learn about their experiences. Upon completion of the thesis, the RA and I will provide ANS with a letter thanking participants with an enclosed summary of the study's findings.

4.2.1.2.4 Nursing faculty

To recruit faculty in 2002-3, I presented a 20-minute overview of the research proposal to nursing faculty. An e-mail letter was sent to all nursing faculty, inviting them to attend. A total of twelve faculty members participated in my presentation.

In 2004-5, I invited faculty to participate by sending them a letter via e-mail forwarded to them by the chief administrator (see Appendix B). Based on preliminary findings from 2002-3, I was interested in recruiting student advisors and clinical teachers about their experiences with ANS, so I especially targeted this group by a specific letter in their mailbox (see Appendix E). Upon completion of the thesis, the RA and I will offer a seminar to nursing faculty at the two research sites to present the study's findings and facilitate collaboration in devising recommendations to promote more inclusive teaching strategies. Participating faculty will be provided with a summary of the study's findings.

4.2.1.2.5 Key informants

I employed a purposive/theoretical sampling strategy in the recruitment of key informants to fully elaborate and validate theoretically derived variations discerned in the data (Campbell & Gregor, 2002; Sandelowski, 1995). Through participating ANS and faculty members' stories and descriptions, I began to identify some of the "translocal relations, discourses, and institutional work processes that are shaping the informants' everyday work" (DeVault & McCoy, 2001, p. 755). I was interested in moving beyond the interchanges of the local schools of nursing to track the macroinstitutional policies and practices that organized the research setting (DeVault & McCoy, 2001; Paterson, Osborne & Gregory, 2004). As one of the concluding

questions in the semi-structured interview guide was "if you were conducting this study, whom would you approach for information about the social factors that influence the experiences of Aboriginal nursing students?" (see Appendix F), I relied upon my insights and these referrals to identify individuals deemed knowledgeable about the context shaping ANS' experiences. "Interviewees will be chosen as the research progresses, and as the researchers learn more and more about the topic. She will see what she needs to know and will find out who would know it" (Campbell & Gregor, 2002, p. 77).

I sent a letter via Canada Post or e-mail, inviting key informants to participate in a one hour audio-taped interview (see Appendix F). Ten individuals identified as possible key informants did not respond to my letter inviting them to participate.

In 2004, I placed an advertisement in a quarterly nursing journal entitled, *Aboriginal Nurse*, distributed by the Aboriginal Nurses Association of Canada to approximately 350 of its members. The advertisement asked interested Aboriginal nurses to contact me if they were willing to share their stories about their educational experiences. No honorarium was offered. One nurse contacted me after seeing the advertisement, but we were unable to schedule an interview at that time.

At the beginning of each interview with ANS, faculty, and key informants, participants were notified that a summary of the study's findings would be sent to them, if they chose to provide an e-mail address or mailing address. During the interviews with ANS, the RA brought and shared information about funding sources for ANS to the interview as per L. Smith's research agenda (1999). The interviews were semi-structured (see Appendix G for interview guides) and participants were encouraged to "take the RA wherever they wanted to go." As recommended by DeVault (1990),

“researchers need to interview in ways that allow the exploration of incompletely articulated aspects of women’s experiences” (p. 100). To ground the interviewing in accounts of the ANS’ everyday experiences, we needed to carefully listen to find clues to ANS’ social relations in the interviewee’s “talk” (DeVault, 1990).

Talk about the work undertaken in a setting offers clues to how social relations that operate across boundaries organize it...Embedded in informants’ talk about their work, generously defined, is their tacit knowledge of how to do it, how to concert their own pieces of the work with the work of others and how to work with the texts that coordinate action” (Campbell & Gregor, 2002, p. 79).

At the completion of the interview, the RA provided ANS with a “thank you” card signed by the RA and me, along with the enclosed honorarium in cash. Findings of the study will be shared with ANS in the form of a summary mailed via Canada Post or electronically.

When the RA and I began to experience hearing similar stories and redundancy about the social organization of nursing knowledge and the social relations that organized ANS’ everyday lives, we discussed the stories and our analysis of transcripts. Upon saturation of the data and consultation with the thesis committee, we halted recruitment or sampling (Tuckett, 2004). I notified chief administrators of the schools that we had acquired an adequate sample size, recruitment strategies were successful, and data collection was completed, and thanked them for their support.

4.2.1.3 Description of the sample

The sample was comprised of 31 ANS, 5 Aboriginal nurses, 24 nursing faculty members, 16 key informants, and 135 texts. My description of the purposive/theoretical

sample includes an overview of participating ANS and Aboriginal nurses, nursing faculty, key informants, and texts. I explain how I shifted the investigation from studying the experiences of ANS from the standpoint of ANS to an examination of the translocal and extra local settings to analyze how ANS' experiences were socially organized.

Eventually, however, the researcher will usually need to shift the investigation to begin examining those institutional processes that he or she has discovered to be shaping the experience but that are not wholly known to the original informants. Thus a second stage of research commonly follows that usually involves a shift in research site, although not in standpoint. Often, this shift carries the investigation into organizational and professional work sites...the researcher may use text and discourse analysis to examine the textual forms and practices of knowledge that organize those work processes. But interviews continue to play an important role here as well, whether as the primary form of investigation or as a way of filling in the gaps of what the researcher can learn through observation and document analysis (DeVault & McCoy, 2001, p. 756).

Sampling numbers or the "n" reflects the summation of the number of interviews, participant observations, journal entries, and texts from the schools of nursing and professional nursing associations (Sandelowski, 1995). The total number of participants was 76. Thirty-one interviews were conducted with ANS. Five interviews were conducted with Aboriginal nurses to gather historical information about the experiences of ANS. I interviewed 24 nursing faculty members to grasp an understanding of the translocal and 16 key informants to gather their perspectives of the broader social context shaping ANS' experiences (extralocal).

I conducted 150 hours of fieldwork in one school of nursing in 2002-3. The RA conducted 39 hours of field work at two schools of nursing, while I conducted an additional 11 hours of fieldwork in both research settings in 2004. The total number of fieldwork hours was 200. Fieldwork included our observations of meetings with administrators and staff from both sites during access negotiations. In 2002-3, I documented field notes of my experience in classrooms and laboratory practice sessions as I "shadowed" two ANS as they attended lectures and laboratory practice sessions. I observed six participating nursing faculty members as they taught ANS and other students in the classroom and lab. Fieldwork also included the RA's and my observations of the setting prior to, during, and after each interview with participating ANS and faculty.

4.2.1.3.1 Overview of Aboriginal students and nurses

In discussions with my committee during the proposal phase, I hoped to recruit at least 30 ANS based upon an ethnographic study of ANS, in which Ryan (1992) examined the local setting of a Western Canadian school of nursing. Sandelowski (1995) explained that inadequate sample sizes could hamper the credibility of qualitative research findings. As cited in Sandelowski (1995), Morse recommended that some ethnographic studies directed towards examining experiences should include 30 to 50 interviews and/or observations (1994). Of course, I was deeply concerned in 2002-3 when only two ANS were recruited.

Adequacy of sample size in qualitative research is relative, a matter of judging a sample neither small nor large per se, but rather too small or too large for the

intended purposes of sampling and for the intended research product
(Sandelowski, 1995, p. 179).

In 2004, the RA recruited and conducted 29 interviews with ANS in a 6-week time frame, making the total number of participating ANS to be 31.

Additionally, I conducted interviews with five Aboriginal nurses (two of these participants were also members of the advisory council). I contacted these individuals and they agreed to volunteer and tell me about their educational experiences in Canadian schools of nursing. This data helped me further examine the historical context that shaped the everyday world of ANS in that these nurses acquired their nursing education several years ago to 20 years ago. Their stories were rich in data as these individuals had time to reflect upon their past experiences as ANS.

Because we advertised for ANS and nursing faculty to participate in the study, we could not select participants other than stipulating that participants were included if they were ANS enrolled in the participating schools. These participants volunteered to tell their stories about their experiences in the schools of nursing. This type of sampling technique is known as secondary selection (Morse, 1998). Maximum variety sampling, however, was eventually accomplished in that the sample of ANS became heterogeneous and included these demographic variables: (a) gender – male and female, (b) community of origin – urban or rural (northern), (c) status – First Nation or Métis, (d) age range - young adult to middle-aged, (e) relationship status - single, partnered, (f) number of dependents – zero to eight, (g) year in nursing program – one to four, (h) admission procedure – nursing access program versus typical “mainstream” admission, (i) funding – Band funded, Canada Student Loan, or other sources. These

kinds of demographic variations were exactly what we hoped to acquire in the sample of ANS. "The researcher's purpose in an IE investigation is not to generalize about the group of people interviewed, but to find and describe social processes that have generalizing effect" (DeVault & McCoy, 2001, p. 753). I need to clarify that we were not aiming for categorical descriptions, but for various ANS' experiences in our analyses that mapped how the ANS' everyday life was drawn into a common set of organizational processes. I conceived this kind of selection in terms of diversity of ANS' experience rather than categorically (DeVault & McCoy, 2001). For example, I was able to gather a diversity of ANS' experiences in that 9 ANS grew up in large cities while 27 ANS relocated to an urban centre from northern Aboriginal communities to acquire their nursing education. This diversity in the ANS' past experience aided my data analysis in that I was able to map how the diversity of experience was still drawn into a common set of coordinating and organizing processes in the institution.

Thus interviewees located somewhat differently are understood to be subject, in various ways, to discursive and organizational processes that shape their activities. These institutional processes may produce similarities of experience, or they may organize various settings to sustain broader inequalities (DeVault & McCoy, 2001, p. 753).

While 21 ANS entered into nursing education via an available access program, 15 ANS entered the school of nursing as "mainstream" students so I was able to compare availability of resources to these diverse groups with inequalities of services available to the "mainstream" students. Please see the Table 2 on page 99 with my description of the sample.

Table 2*Profile of participants*

Description	Gender	Descent	Admission	Funding Source	Origin	Relationship Status	Number of Dependents
ANS* n=31 Aboriginal Nurses n=5	Male=2 Female=34	FN** = 28 Métis = 8	Access*** = 21 Regular = 15	Band+ = 28 Student Loans = 4 Other=4	Urban = 9 Rural or northern = 27	Single++=15 Partnered = 21	0 = 12 1-3 = 18 4 - 8 = 6
Faculty n=24	Male=1 Female=23	0					
Key Informants n=16	Male=3 Female=13	FN=4 Métis=1					

Note. Total number of participants - 76.

* ANS were recruited from 2 Canadian schools of nursing and represent various years in undergraduate nursing programs. 2 students recently exited the nursing program.

** FN designates that participants identified themselves as having First Nations ancestry. "First Nations" has gained wide acceptance in Canada since the early 1980s, promoted from within the Indigenous community as a substitute for band in referring to any Aboriginal group formally recognized by the government. While it includes Status, Non-Status, Treaty, Non-Treaty Indians, it specifically does not include people that identify themselves as having Inuit or Métis ancestry. Whereas, M designates Métis which is a term used to describe descendants of Indigenous peoples and French settlers or fur traders.

*** Access programs were established to assist academically, economically, and socially disadvantaged residents to facilitate their pursuit and acquisition of a postsecondary education. Access programs provide a preparatory year, tutoring, bursaries, and personal counseling.

+ Successful First Nations applicants acquire sponsorship from their Band to cover tuition, some books, and a negligible living allowance.

++ 25% of participating ANS identified themselves as single with dependents.

4.2.1.3.2 Nursing faculty

In 2002-3, 15 faculty members participated in the study. I conducted one-hour semi-structured audio taped interviews with nursing faculty who volunteered to participate.

In 2004-5, another 9 faculty members volunteered to participate. Of these, three teachers participated in a focus group (by their choice), which was moderated by me. The purposive/theoretical sample of nursing faculty was 24. Most nurse educators were female, white and middle-aged. One faculty member was male. Numbers of years experience in nursing education varied from 1 – 25 years, but the majority had over 10 years experience. Most faculty members were involved in classroom or laboratory sessions, while four faculty members assumed the roles of clinical teachers. Although I had specifically recruited student advisors and clinical teachers, only two student advisors and four clinical teachers volunteered to participate.

During the latter portion of data collection, interviews with educational administrators were conducted (DeVault & McCoy, 2001). To protect the identities of educational administrators, I categorized them as nursing faculty. I focused my questions on trying to uncover the social and textual organization of the school's position about recruiting and retaining ANS (DeVault & McCoy, 2001).

4.2.1.3.3 Key informants

Key informants were recruited based upon perceptions of their knowledge about the broader context shaping ANS' experiences. The total number of key informants was 16. I conducted face-to-face interviews with all key informants in their offices. Two participants requested to be interviewed together. Interviewing is:

driven by faithfulness to the actual work processes that connect individuals and activities in the various parts of an institutional complex. Rigor comes not from technique – such as sampling or thematic analysis – but from the corrigibility of the developing map of social relations (DeVault & McCoy, 2001, p. 764-5).

4.2.1.3.4 Texts

The majority of texts referred to by ANS and Aboriginal nurses were performance improvement plans (PIPs), clinical evaluation forms, and course syllabi. To discern how nursing knowledge was socially organized, I randomly purchased a nursing textbook and course syllabus from one nursing course in each year. Nursing faculty members also talked about PIPs, clinical evaluation forms, and course syllabuses. Several nursing faculty members provided me with a blank copy of a PIP. Key informants talked about admission policies and procedures for ANS and access students. I gathered these texts about the admission policies from the appropriate departments at the postsecondary institutions.

Texts appear in people's talk because they are an integral part of what people do and know. The texts that researchers see being used by informants during field observations are often central to everything that happens. Therefore to understand the setting and explicate the problematic arising in it, texts are a very useful ethnographic data source (Campbell & Gregor, 2002, p. 79).

I also collected mission statements and reviewed websites from the schools of nursing, access programs, major employers of Aboriginal nurses, and the provincial nursing association to analyze mission statements, policies and procedures. The total number of texts collected was 135.

A common aspect of IE research at this second stage involves the researcher's investigating institutional work processes by following a chain of action, typically organized around and through a set of documents, because it is texts that co-ordinate people's activity across time and place within institutional relations (DeVault & McCoy, 2001, p. 756).

4.2.2 Relationship between researcher and researched

An important component of qualitative methods is the relationship between the researcher and those studied. Due to the nature of the study, I tried to establish rapport with ANS, Aboriginal nurses and key informants. "Your relationships with the people in your study can be complex and changeable, and these relationships will necessarily affect you as the 'research instrument,' as well as have implications for other components of your research design" (Maxwell, 1998, p. 86). Reflexivity was often used to reflect the unavoidable mutual influence of the research participants and the researcher on each other (Maxwell, 1998).

Throughout the study, I reflected on my role in the relations of the ruling and documented these reflections in a detailed journal via field notes (Smith, 1987). Important concerns were the power of the researcher in relation to the researched and existing power relations in the research setting, and how research knowledge was going to be used (Campbell & Gregor, 2002). "For institutional ethnographers, the conceptualization of power as ruling is decisive for how the inquiry is taken up" (Campbell & Gregor, 2002, p. 67).

Using the social organization of knowledge as a theoretical lens, I was required to assume the standpoint of the researched – the ANS, share findings, and work with

ANS and/or Aboriginal nurses to enhance the educational experiences of Aboriginal people in nursing. The RA and I debriefed on a biweekly basis to discuss situations and circumstances in which it was easy or difficult for us to assume the standpoint of ANS.

A notion of strong reflexivity would require that the objects of inquiry be conceptualized as gazing back in all their cultural particularities and that the researcher, through theory and methods, stand behind them, gazing back at his own socially situated research project in all its cultural particularity and its relationships to other projects of his culture—many of which (policy development in international relations, for example, or industrial expansion) can be seen only from locations far away from the scientist's actual daily work (Harding, 1991, p. 163).

Anderson (1991) noted that empowerment began within the actual research encounter. For example, when interested ANS were contacted to arrange an interview date and time, they were requested to choose a convenient interview date and time and during informal information sessions, ANS were provided with information about the Aboriginal Nurses Association of Canada, which articulated sources of bursaries and student loans.

My power as the researcher was complicated by the fact that I was a Non-Aboriginal researcher and former nurse educator studying ANS' experiences (Alcoff, 1991; Ramsden, 2002; L. Smith, 1999). To advise me on how to redeem a more-equal relationship with participants, I consulted the RA and the five Aboriginal nurses that were members of the advisory council. The advisory council members initially reviewed a summary of the findings of the first few transcripts and took part in one teleconference

where I pondered the ANS' reticence to participate in the study. I provided up-dates to the advisory council members about the research process on a biannual basis. The RA and I sent an initial draft of a paper to advisory council members for their perusal. I informally met with several advisory council members.

Although I conducted 150 hours of fieldwork over two sessions at one school of nursing (site #1), I was only able to recruit two ANS into the study during 2002-3. During the fieldwork, one ANS was slightly uncomfortable with my presence in the laboratory practice sessions until I contributed to learning by being a "mock patient." In the subsequent interview, this ANS said that the reciprocity of the relationship was an important feature that facilitated a comfort level between us. During fieldwork with another ANS, the student began to question the actual purpose of the fieldwork when I loaned her and other students reference material for an assignment. The ANS did not understand that I was attempting to use reciprocity in the research relationships; rather, she questioned if I was aligning myself with Non-Aboriginal students.

In the interview process with ANS in 2002-3, I brought cups of coffee for the interviewees. I tried to emulate that I was a researcher and a person who believed that ANS were the experts about their experience. Based upon excerpts of these first two transcripts, field notes, and the fact that I had limited success in the recruitment of participants, I deduced that ANS were reticent to share their experiences with a Non-Aboriginal, white, middle-aged doctoral student and former nurse educator (Martin, 2002).

In the field, I noted that ANS were more comfortable approaching the RA with questions about the study and in discussing their experiences as student nurses. For

example, in one informal information session held for recruitment, as soon as the RA introduced herself and mentioned the communities where her family originated, several ANS became engaged in conversations with the RA about the First Nations communities and mutual acquaintances. In another information session, ANS approached the RA with their questions about anonymity and then the RA brought the question forward to me. I provided the RA with the answer and the RA approached the ANS with the answer. By using reflection in my journal, I deduced that these interactions illustrated that the students had a connectedness with the RA, while ANS experienced less comfort interacting with me. Tenets of cultural safety encouraged me to reflect upon my positionality as a white, middle-aged, doctoral nursing candidate in that my standpoint influenced ANS' discomfort in approaching me with valid concerns and questions. By collaborating with an Aboriginal nurse as the RA for the remainder of the study, I used reflexivity and discussions with the RA to provide me with further insight into the importance of historical factors coming into play when ANS interacted with a Non-Aboriginal, middle-aged woman who previously was a nurse educator. Because of the primacy of historical features in Aboriginal epistemology, ANS were more comfortable sharing their concerns and questions with an Aboriginal nurse than a Non-Aboriginal doctoral nursing student.

Recruitment of faculty and key informants was somewhat more successful. I typically arranged with interested faculty and key informants that I would conduct the interview in their offices at a mutually convenient date and time. Frequently, I would prearrange to bring the faculty member or key informant a cup of coffee or tea of their choice. Faculty members and key informants were more apt to be comfortable with me

if they were familiar with me or due to commonalities of our experience. Because I had previous experience as a faculty member and was a doctoral nursing student, I detected minimal power differentials between faculty members and myself. However, I noted particular power relations during an interview with a senior faculty member, who insinuated that I was only conducting research about ANS' experiences because there was funding available for such studies rather than me having a keen personal interest in the topic.

Similar to other critical ethnographers' experiences (Campbell & Gregor, 2002), I observed some skepticism on the part of some participants as to what the purpose of the study entailed and what the findings might unearth about their organizations. I approached twenty-six individuals that were identified as potential key informants for the study. Of these twenty-six individuals, ten avoided responding to my invitation to participate and 16 agreed to volunteer to participate.

Faculty and key informants were interested in receiving a copy of the summary of the study's findings, upon completion of the study. One key informant with Aboriginal ancestry expressed that nursing faculty might be more receptive to hearing about their institution from the RA and me because we were perceived as nurse researchers (insiders – not outsiders).

"The recognition that there is a problem in speaking for others has arisen from two sources" (Alcoff, 1991, p. 6). The first source stems from my social location as a white, middle-aged, upper-middle class woman with my family of origin being working class. I disclosed to all participants that I was a doctoral nursing student and former nurse educator. My social location has an epistemologically significant influence, which

can authorize or disclaim ANS' voices. To strengthen my ability to authorize ANS' voices, I worked diligently to establish a sense of teamwork with the ANS, RA, committee members, advisory council members, and executive members of the Aboriginal Nurses Association of Canada as per L. Smith's research agenda (1999).

"The second source involves a recognition that, not only is location epistemologically salient, but certain privileged locations are discursively dangerous" (Alcoff, 1991, p. 7). In light of the fact that the practice of privileged persons speaking on behalf of disenfranchised people actually resulted in increasing oppression in some instances, the RA and I were particularly diligent in protecting the identities of all participants and the participating schools of nursing. I focused on addressing hegemony²⁹ in schools of nursing. When presenting findings, my social location will be acknowledged along with its discursive context (Alcoff, 1991). By presenting the analysis of the data and the "mapping" of social relations, a scientifically sound study will be upheld.

4.2.3 Data collection

"Possibly nothing is more important to data collection than a good grasp of what institutional ethnography can do and how it does it" (Campbell & Gregor, 2002, p. 59). During the proposal stage of the study, I worked with my committee and the advisory council to establish what would constitute data. Institutional ethnography relies on interviews, participant observations, and documents as data (Campbell, 1998). During

²⁹ The word, hegemony, was derived from the Greek term *egemonia* or *emenon*, meaning leader, ruler of political predominance. Hegemony refers to the psychocultural aspects of control, and the role of cultural institutions within this control. This control is achieved through the social and cultural realms where it is more effectively invisible, more pervasive. Hegemony 'saturates' even what we think of as 'common sense' as it becomes part of our lived system of meanings and values.

the initial interviews with ANS, intersubjective constructions of knowledge of the everyday world of ANS began. Data sources included:

1. one-hour audio taped semi-structured interviews with ANS and Aboriginal nurses with the resultant transcripts,
2. one-hour audio taped semi-structured interviews with faculty and their transcripts,
3. one-hour audio taped semi-structured interviews with key informants,
4. field notes that included participant observations with ANS, other nursing students, and faculty in classrooms and laboratory practice sessions, accounts of informal "talking" with ANS, other nursing students, and faculty and our reflections and reflexivity as recorded in a journal format, and
5. texts such as nursing textbooks, course syllabi or course outlines, application forms, websites from the schools and professional nursing associations.

I describe each of the particular sources of data in the following subsections.

According to Campbell and Gregor (2002),

The techniques employed in doing interviews and observations in institutional ethnography are the practices of field methods that any ethnographer would use. Perhaps the key point about using field methods in institutional ethnography is figuring out what, out of all the possibilities, is useful to observe or otherwise pay attention to and record (p. 71).

4.2.3.1 Interviews with Aboriginal nursing students and nurses

"The first step in the process of institutional ethnography is an examination of the experiences of members of the group from whose standpoint the inquiry is being

conducted, in relation to the institution under study" (O'Neill, 1998, p. 132-133). The RA and I conducted formal and informal interviews as well as participant observations to examine the ways in which the ANS describe and enact their experiences in the everyday world. "Norms" and "things taken for granted" were identified and explored in detail.

At one end of the continuum are planned interviews, where the researcher makes an appointment with someone for the purpose of doing a research interview. Then there is the kind of "talking with people" that occurs during field observation, when the researcher is watching someone do his work and asks him to explain what he is doing, why he did what he just did, what he has to think about to do the work, where this particular document goes, and so on.

"Informal," on-the-spot interviews can be combined with later "formal" or planned interviews, in which the researcher brings to the longer interview a set of questions or topics based on the earlier observation-and-talk (DeVault & McCoy, 2001, p. 756-757).

Because we were aiming for a picture that displays the social activity sustaining a particular institutional nexus or arena, this analytic goal gave rise to several distinctive ways to conduct interviews (DeVault & McCoy, 2001). The RA and I developed a semi-structured interview guide that was used to seek ANS' descriptions of how the work of an ANS is socially organized. The RA and I recognized the importance of reflexivity and were apt to share insights and information with participants during the course of the interview. For example, the RA provided ANS with information about funding sources.

The RA and I adopted Holstein and Gubrium's conceptualization of active interviewing (2003). We thought of the interviews as semi-structured interpersonal interactions that would develop a broader image of reality as an ongoing, interpretive learning process for both the interviewee and the interviewer. We regarded participants as 'knowers' and experts in their everyday experience. We asked ANS to describe their everyday lives and tell us what happens. "The subject/knower of inquiry is not a transcendent subject but is situated in the actualities of her own living, in relations with others (Smith, 1992, p. 92). In keeping with the social organization of knowledge framework, we asked participants to work with us to decipher how ANS' experiences happened.

The interviews were scheduled at a mutually convenient date and time in an available interview room at the participating research sites. The RA would contact the ANS the day before the interview to remind them of the scheduled appointment and reschedule if necessary. Prior to the interview, the RA reviewed the informed consent with the ANS (see Appendix H for all informed consents) and provided the ANS with a signed copy. The RA turned the audiotape recorder on and began by stating that she had some questions to guide the interview, but the ANS could "take her wherever they wanted to go." Interviews lasted between 30 and 60 minutes. At the conclusion of the interview, the RA asked ANS if they had anything else to say. Once the ANS acknowledged that there was nothing further to share, the RA turned the tape recorder off. The RA handed the ANS an envelope that contained a "thank you" card signed by the RA and me with the enclosed honorarium.

Several times, ANS talked more about their everyday lives once the tape recorder was turned off. The RA documented her observations about the interview and the nature of these informal "talks" in field notes, protecting the identity of the ANS by altering identifiable features in their stories.

"Most IE interviewers tape conversations with informants, both as an aid in making notes and to preserve details whose relevance may not be immediately obvious" (DeVault & McCoy, 2001, p. 758). The audiotapes of interviews with ANS, Aboriginal nurses, faculty, and key informants were sent to a transcriptionist to be transcribed. The transcriptionist e-mailed the first draft of the transcript of an interview with an ANS to the RA. The RA reviewed the transcript and removed any identifying features such as names of individuals, locations, and the school of nursing. The RA altered other identifying features, but kept the essence of the experience intact. For example, if the ANS initially described inadequate health care provision to an aunt with diabetes, the RA altered the story to inadequate health care provision to a cousin with cardiovascular disease³⁰. The RA sent the revised transcript back to the transcriptionist, who forwarded the text to me. Transcripts were labeled as Student #1,2,3, etc.

I reviewed the initial transcripts of interviews that I conducted with Aboriginal nurses, faculty, and key informants and removed identifying features. Aboriginal nurses' transcripts were labeled Aboriginal Nurse #1-5. Faculty member's transcripts were labeled Faculty #1,2,3, etc. Key informants' transcripts were labeled Key #1,2,3, etc.

³⁰ Thesis committee members and I acknowledged that such changes might prove to be problematic as they could alter interpretations of the data. However, these changes were given careful consideration and agreed upon by the committee as a way of protecting participants' identities.

For two reasons, I reformatted the document into a text file and incorporated the text file into a qualitative research software program called N6 Student, the latest version of Non-numerical Unstructured Data Indexing Searching and Theorizing (NUD*IST). Firstly, the data was monumental and I wanted to keep it well organized. Secondly, I used the software program to organize data analysis, which I will discuss shortly.

4.2.3.2 Interviews with faculty members

With a theoretical lens that ANS' everyday world is influenced by people in translocal and extralocal settings, I examined faculty's experience teaching ANS through participant observation and interviews. My standpoint and previous experience as a nurse educator helped me to discern that nursing faculty were frontline professionals that were especially important because they "make the linkages between clients and ruling discourses, 'working up' the messiness of an everyday circumstance so that it fits the categories and protocols of a professional regime" (DeVault & McCoy, 2001, p. 760). Interviewing nurse educators presented a distinctive challenge in that faculty members were trained to use concepts and categories that I wanted to "unpack." Because nursing educators were accustomed to speaking from within a ruling discourse, I maneuvered my questions to encourage faculty to talk about what actually happens rather than talking about teaching jargon and rhetoric. "Professional training in particular teaches people how to recycle the actualities of their experience into the forms in which it is recognizable within institutional discourse" (D. Smith, 1986, p. 8). People who work in a large organization or large profession such as nursing, for instance, will be members of a discourse that has a shared language, beliefs and

values, and ways of working (Campbell & Gregor, 2002). Because of my previous experience as a nurse educator, I was privy to some aspects of the shared language, but genuinely required further explanations about some phrases or acronyms. For example, several faculty members and students referred to "PIPs," which was unfamiliar to the RA and me, so we asked participants to further explain the terminology. We deciphered that PIPs were documents known as performance improvement plans or contracts between the students and the teachers.

I scheduled and conducted one-hour audio taped interviews with faculty who volunteered to participate at a mutually convenient date and time. Interviews generally took place in the faculty member's office. Sometimes, faculty members chose to sit behind their desk while other faculty members moved their chair to come and sit closer to me. One faculty member wanted me to conduct the interview in a coffee shop close to the school. The focus group interview with three faculty members occurred in a staff lounge as per their choice. Three faculty members negotiated to be interviewed at their homes.

Following a review of the consent form, I provided each faculty member with a copy of the signed form. When the faculty member agreed, I turned the tape recorder on. I used a semi-structured interview guide (see Appendix I) and began the interview by stating that I had questions to guide the interview process, but the interviewee could lead me wherever they wanted to go. Prior to the conclusion of the interview, I asked nursing faculty if they had anything else that they wanted to tell me. When nursing faculty indicated, I turned the tape recorder off.

4.2.3.3 Interviews with key informants

An examination of broader social context shaping ANS' experience was conducted by interviewing individuals that I refer to as key informants. "Talk about the work undertaken in a setting offers clues to how social relations that operate across boundaries organize it" (Campbell & Gregor, 2002, p. 79). An important feature of the inquiry was to see how ideas and social forms of consciousness might originate outside of ANS' experience. As suggested by DeVault and McCoy (2001), I usually used interviews with ANS and faculty as sources of information or pointers towards potential key informants. I sent a letter to the key informant and invited them to participate in a one-hour audio taped interview.

Depending on the geographical location of the key informant, I conducted one-hour audio taped telephone or in-person interviews. In-person interviews were usually conducted in the individual's office or a conference room in their workplace.

4.2.3.4 Field notes

"When institutional ethnographers conduct observations, besides making note of what is happening, they listen for the sort of informants' talk that contains and expresses their expertise of living their lives" (Campbell & Gregor, 2002, p. 69). I needed to observe the actual ongoing practices of actual individuals (Smith, 1992). In 2002-3 I conducted 150 hours fieldwork with 2 participating ANS in various classrooms and laboratory practice sessions, provided I had permission from the corresponding nursing faculty member. Going into the schools of nursing to conduct participant observations was an open-ended undertaking, because the RA and I had to remain

open to see what was happening. I used Wolcott's suggestions to enhance our participant observations (2001). These strategies were:

- I told the ANS and nursing faculty that I was observing the learning environment in that I wanted to understand the experiences of ANS from the standpoint of ANS,
- We reviewed constantly what we were looking for and listening to – stories about the everyday lives of ANS,
- We capitalized on “bursts” of vignettes or conversational exchanges that captured the essence of ANS' work,
- We assessed and evaluated what we were doing during the fieldwork, what we were observing, and what we were documenting, and
- We knew that we needed information about the actualities of the ANS' experience and wanted to learn how they were socially organized.

As soon as possible following the fieldwork, the RA and I recorded personal accounts of the participant observations in field notes, which became a rich resource as I learned how to see, hear about, and otherwise understand what ANS *do* in the course of their everyday lives (Campbell & Gregor, 2002).

In 2004-5, the RA conducted 30 hours of fieldwork with the 29 participating ANS in the schools of nursing. The RA recorded field notes about her visits to the schools and included reflections of how she understood the work of ANS. As Wilson (1987) explained, there are many different types of field notes: observational notes, methodological notes, and personal notes. I used Wilson's format in a previous ethnographic study and was comfortable with this way of documenting the fieldwork, so

I adapted this format for this critical ethnography. The RA and I reviewed field notes in our biweekly meetings, making a practice of including date, time, and place along with personal reflections. We removed identifiable features and revised the field notes accordingly. I converted the field notes from documents to text files and incorporated them into the software program for analysis.

4.2.3.5 Texts

"A prominent aspect of institutional ethnography is the recognition that text-based forms of knowledge and discursive practices are central to large-scale organization and relations of ruling in contemporary society" (DeVault & McCoy, 2001, p. 765). The textual mediation of social relations and forms of organization has the "miraculous effect of creating a joint between the local and particular (on one hand) and the generalizing and generalized organization of the relations of ruling (on the other), making the latter investigatable in a new way" (D. Smith, 1992, p. 93). In this study, texts mean documents or representations that have a relatively fixed and replicable character, such as textbooks, student application forms, paper documents such as performance improvement plans, course syllabi, nursing textbooks, nursing standards, school's policies and procedures, nursing profession's policies and procedures and various websites and computer files. Because texts can be stored, transferred, copied, produced in bulk, and distributed widely, these texts are allowed to be activated by users at various times and locales (DeVault & McCoy, 2001; D. Smith, 1992).

As data collection and analysis was occurring simultaneously, I became more adept at asking faculty and key informants to talk in detail about a text or those aspects of a textual process that the interviewee knew. To find out how ANS' everyday lives

were organized, I located texts and text-based knowledge forms in the schools' and nursing profession's operation. I collected the texts and website addresses and reviewed them.

The data collection process required that I tracked back and forth or followed clues forward from the local setting and the data that was collected there. Data collection required connections between the data and the social organization of knowledge. "Bringing data together with theory happens explicitly in the process of analysis" (Campbell & Gregor, 2002, p. 81).

4.2.4 Data analysis

The fourth component of qualitative research is data analysis. "A successful analysis supersedes any one account and even supersedes the totality of what informants know and can tell" (Campbell & Gregor, 2002, p. 85). As IE is fundamentally an analytic project, analysis on the part of the researcher needed to begin at the proposal stage and continued throughout data collection and the analysis phase of the project. However, the stages of analysis do not occur chronologically – I moved back and forth between data collection, reading, thinking, analyzing, discussing, and writing.

I used this question as a guide while reading transcripts, field notes, and texts: "What does the data tell me about how these schools function to influence the everyday lives of ANS?" A distinct feature about this research method is that it explicates the experience; it is not a simple description of the experiences of ANS. My analysis used what participants know and what they were observed doing. My analysis focused on identifying captions in the transcripts, field notes, and texts for the purpose of identifying, mapping, and describing the social relations that extend beyond the

boundaries of the participants' experience. Data analysis was driven by this study's purpose, which was to explore the 'concerting' of ANS' everyday lives and the social relations that generated the varieties of lived experiences of the ANS (Campbell & Gregor, 2002; D. Smith, 1999).

Like some critical ethnographers, I utilized qualitative data analysis software called QSR N6 Student, the latest version of NUD*IST line of software designed with student needs in mind. N6 Student offered me relatively inexpensive features to import text data with flexible document management systems. I used the software to:

group chunks of transcript, sometimes pages in length by theme or topic... This kind of computer-aided sorting works at a fairly primary level and offers researchers a manageable way to work with large numbers of interviews; it still leaves the analytic work to be done, as always, through writing, thinking, and discussion with collaborators and colleagues (DeVault & McCoy, 2001, p. 768-9).

I grouped the analysis rather simply, sticking closely to conversation topics about ANS' everyday lives and references to institutional sites and processes.

Similar to Townsend's approach in her study of occupational therapists in mental health services (1996), I followed three analytic processes. Firstly, I used reflection and collaborated with the RA and the thesis committee to work from the standpoint of the ANS in undertaking the task of describing the everyday world of ANS. I read and reread the ANS' (n=31) and Aboriginal nurses' (n=5) transcripts – one by one and then in groups. Using an approach described by Browne (2003), entire transcripts and corresponding field notes were read and reread to identify similar, converging or contradictory patterns of ANS' experiences, key concepts about the work of ANS, clues

to ruling relations, and linkages to the social organization of nursing knowledge. I asked the RA to choose specific transcripts to review separately and then together. We compared, contrasted, and discussed our analysis. The same transcripts were then forwarded to Dr. Joan Anderson, Chair of the Thesis Committee, to separately review. On several occasions, the RA and I met with Dr. Anderson in-person to compare, contrast, and discuss our findings.

Secondly, I explored and explicated the actualities of the experience, rather than those of a generalizing science (Seibold, 2000). The second analytic process involved searching the data to link, map, or trace the social processes that connected the everyday world of ANS with the work of the nursing faculty. I read and reread each transcript and their corresponding field notes and then progressed to read and reread groups of transcripts to delineate similar, converging, or different patterns of nurse educators' experience teaching ANS. With the assistance of the RA, I was able to stay focused on the standpoint of the ANS, rather than assume the standpoint of faculty. Through a back-and-forth method of exploration, I examined the data to trace connections between ANS' everyday life and the associated texts or other social processes that governed the students' lives. I used strategies suggested by Campbell and Gregor (2002) in that I talked with the RA and the chair about findings from the data. Being an extrovert, I found it helpful to talk about the pieces of the puzzle and then put them together.

I progressed from there to access extended social relations occurring inside and then outside of the school of nursing. When interpreting the data, I explored and explicated linkages that were the actualities of people's lives. The data guided the

interpretation, not a priori theory (Campbell & Gregor, 2002). I examined the "ideological character" of the educational process occurring within these schools of nursing. I examined all transcripts, field notes, and texts for conceptualizations and categories emulating Aboriginal peoples, ANS, student nurses, nursing faculty, knowledge, nursing education, and nursing practice. I re-read and examined all transcripts, field notes, and texts for traces of information that revealed how ANS' everyday lives were co-coordinated and regulated through textual facts (DeVault & McCoy, 2001). My task was to:

search out, come to understand and describe the connections among these sites of experience and social organization...Being able to count on using social relations to discover the concerting of action across time and space is what makes the inquiry methodical...The question to be explored is "What are the social relations coordinating those experiences?" (Campbell, 1998, p. 62)

Data analysis occurred by and through writing and rewriting. Writing and rewriting the findings of the study began to make something out of the data, and helped move me through analysis. Writing altered the data from a massive collection of documents to "analytic writing." Writing and rewriting the findings into stories began the process of making use of the data as evidence. The data held my writing to the accounts of the ANS (Campbell & Gregor, 2002). Campbell and Gregor (2002) noted that writing the analysis is a challenging process in that researchers might have difficulty translating their understanding of the social relations in a setting into a written argument supported by the data.

I shared preliminary findings with the RA, thesis chair and committee, and the Advisory Council. By sharing preliminary findings, I was able to step back and see where my analysis and argument was strong and places where I needed to strengthen the linkages (Campbell & Gregor, 2002; Martin, 2002; Martin & Kipling, 2005). Findings explicated the experience of ANS and revealed what is happening relevant to the standpoint of ANS. By focusing on social relations and the institutional processes organizing them, this form of analysis identified the actual workings of the schools of nursing.

4.2.4.1 Ensuring scientific quality

Researchers using quantitative methods generally attempt to design controls that address both anticipated and unanticipated threats to validity.

Qualitative researchers, on the other hand, rarely have the benefit of formal comparisons, sampling strategies, or statistical manipulations that 'control for' the effect of particular variables, and must try to rule out most validity threats after the research has begun, using evidence collected during the research itself to make these 'alternative hypothesis' implausible (Maxwell, 1998, p. 91).

Making meaning of the data that stands up to relevant scientific tests is the purpose of any scholarly analysis.

I established the validity, warrantability, or truth-value of my analysis within the tenets of the theoretical and methodological perspectives. Supported by Aboriginal epistemology and conventional ethnography, triangulation provides evidence to specific findings, while the ethnographer attempts to explicate how the local settings (including

local understandings and explanations) come about. By using the data to map the social relations, I relied

on the possibility that truth can be told in the following very ordinary sense: that when people disagree about statements made about the world, accuracy or truth is not decided on the basis of 'authority' or on the shared beliefs of a community but by referring back, in principle at least, to an original state of affairs, extraneous to the accounts they have given. In a sense, it wants an account of knowledge that takes for granted that people's experiences are various and can be coordinated, and that a social theory of knowledge grasps it as a definitive mode of coordinating people's activities (D. Smith, 1999, p. 97).

Providing an account that explicates the social relations of schools of nursing is what this analysis achieved (Campbell & Gregor, 2002).

I chose criteria of validity that best suited the theoretical and methodological perspectives and the method of inquiry (Heron, 1988; Sandelowski, 1986). Using aspects of Lather's (1991) reconceptualization of validity for research committed to just social order, I discuss these aspects of rigor: triangulation, construct, face, and catalytic validity (1991).

4.2.4.1.1 Triangulation

Similar to the importance of gathering information from multiple sources in Aboriginal epistemology, Lather (1991) expanded the notion of triangulation from meaning multiple measures to include multiple data sources, methods, and theoretical schemes. Multiple data sources was achieved in that the sample included a diverse account of ANS' experiences, faculty members, key informants, the RA's and my field

notes, websites and texts. Multiple methods of data collection were implemented: interviews, participant observations in the fieldwork, acquisition of nursing texts and school documents. Multiple theoretical schemes were used to guide the study.

4.2.4.1.2 Construct validity

“Determining that constructs are actually occurring rather than mere inventions of the researcher’s perspective requires a self-critical attitude toward how one’s own preconceptions affect the research” (Lather, 1991, p. 67). Relying on a tenet from cultural safety about the importance of reflexivity and acknowledgement of location and positionality, a systematized reflexivity, which demonstrates how a priori theory was changed by the logic of the data, was essential in establishing construct validity (Lather, 1991). I identified “piori” theories in the literature review. I described how I formulated my initial premonitions about the everyday world of ANS in field notes. I collected data that was rich in detail and complete enough that it provided a full and revealing picture of what is going on. Interviews were transcribed verbatim. I revisited the data to test developing theories, rather than simply using the data as a source to support beginning ideas of how ANS’ lives were organized. By mapping how ruling relations influenced ANS’ everyday lives, construct validity was attained.

4.2.4.1.3 Face validity

Face validity is complex and intricately related to construct validity (Lather, 1991). Research with face validity offers the reader an “oh, yes, that’s happened to me” sense of recognition when findings are presented (Lather, 1991). Face validity was operationalized primarily by sharing preliminary findings and through consultations with the RA, thesis committee members, and the advisory council (Lather, 1991). An initial

draft of a paper about the study's findings was provided to advisory council members for review. These Aboriginal nurses reviewed the paper and acknowledged that our findings resonated with their own experiences as student nurses up to 20 years ago.

4.2.4.1.4 Catalytic validity

"Catalytic validity represents the degree to which the research process re-orient, focuses and energizes participants toward knowing reality in order to transform it, a process Freire (1973) terms conscientization" (Lather, 1991, p. 68). The RA and I engaged in conversations and written communications with ANS, faculty, and Aboriginal nurses to provide our interpretation of the social relations in Western Canadian schools of nursing. Being guided by L. Smith's decolonizing methodologies for research and Indigenous peoples, I was committed to collaborating with ANS, Aboriginal nurses, and members of the Aboriginal Nurses Association of Canada as ANS and Aboriginal nurses may choose to incorporate this information to gain a broader contextual understanding of the social relations that organize their everyday lives, and ultimately self-determination. The RA and I engaged in a reciprocal dialogue during interviews and attempted reciprocity during participant observations.

4.3 Ethical considerations

"Ethics pertains to doing good and avoiding harm" (Orb, Eisenhauer, Wynaden, 2001, p. 93). I was required to balance the principles of research with the well-being of ANS. As addressed by L. Smith (1999), violation of human rights in the name of scientific research has been among the darkest events in the colonial and neo-colonial history of Aboriginal peoples.

Just knowing that someone measured our 'faculties' by filling the skulls of our ancestors with millet seeds and compared the amount of millet seed to the capacity for mental thought offends our sense of who and what we are. It galls us that Western researchers and intellectuals can assume to know all that it is possible to know of us, on the basis of their brief encounters with some of us. It appalls us that the West can desire, extract and claim ownership of ways of our knowing, our imagery, the things we create and produce, and then simultaneously reject the people who created and developed those ideas and seek to deny them further opportunities to be creators of their own culture and own nations (L. Smith, 1999, p. 1).

When preparing the research proposal and application for ethical approval, I considered the potential ethical issues that could arise such as informed consent, confidentiality, data generation and analysis, researcher/participant relationships and reporting of findings. Although I acquired ethical approval for this study from Ethical Review Boards at the University of British Columbia and the two research sites, it was problematic for me to recruit ANS into the study in 2002-3. "The desire to participate in a research study depends upon a participants' willingness to share his or her experience" (Orb et al, 2001, p. 93). Due to a possible lack of trust, ANS were not willing to share their experiences with me.

"A balanced research relationship will encourage disclosure, trust, and awareness of potential ethical issues" (Orb, Eisenhauer, & Wynaden, 2001, p. 94). By incorporating the aid of an Aboriginal nurse as a RA, a more balanced research relationship was attained. The RA and I worked diligently at protecting the identities of

participants by altering details of their stories to capture the essence but protect the student from being identified.

I was obliged to consider possible outcomes of an interview and weigh benefits and potential harm. It came to my attention, that several participating ANS and Aboriginal nurses could possibly be survivors of Residential Schools. I anticipated that interviewing survivors of Residential Schools might trigger painful memories causing distress, so I incorporated a section in the consent form that I specifically directed to survivors. I wanted to provide survivors and the interviewer with a "heads up" that the participant might become distressed during the interview. In this case, the RA and I decided that we would stop the tape recorder, provide the participant with time, a glass of water, and a tissue. We would then seek ongoing consent from the participant and let them choose whether or not they wanted to continue with the interview. "Stopping the interview and searching for possible solutions for the participants' distress indicates that researchers are aware of the vulnerability of participants and their rights" (Orb et al, 2001, p. 94). I interviewed two participants who were survivors of Residential Schools. One participant had a positive experience in a Residential School, while the other participant told me that her experience was horrific. This participant said that she was distressed and saddened by her memories, but she wanted to continue with the interview because she thought the study was important. Informed consent provided participants with their right to autonomy – the right to be informed about the purpose, nature, risks, benefits of the study, the right to freely decide about their participation, and the right to withdraw without penalty.

Research strategies in sampling techniques and data collection also have ethical considerations. I wanted to maintain the principle of beneficence as I was aware of potential consequences of revealing the identities of participating ANS, Aboriginal nurses, nursing faculty, schools of nursing, and key informants. Orl et al (2001) recommended the use of pseudonyms. I used Student #1,2,3, etc. and Faculty #1,2,3, etc. to identify the transcripts. The RA was the only member of the research team to have ANS' names, phone numbers, and mailing addresses. The RA reviewed transcripts and field notes, removing names and altered identifiable features. I reviewed the faculty and key informants' transcripts and my field notes and removed names and altered identifiable features. Some committee members knew the names of the participating schools of nursing because they were required to sign the ethical review board applications. When reporting findings, the RA and I will refer to the research setting as two Canadian schools of nursing.

One of the most crucial and distinctive features of the ethical principle of justice is avoiding exploitation and abuse of research participants (Orb et al, 2001). As a white middle-aged female researcher and a doctoral nursing student, I struggled with the notion of speaking on behalf of ANS (Alcoff, 1991; Andersen, 1993; Arvizu, 1995; DeVault, 1995). I conducted some soul-searching in regards to the following questions: What is the "true" purpose of this study? Am I exploiting ANS to acquire a doctoral degree? By speaking about the experiences of ANS, will I be exposing them to further subordination? At this time, I concluded that a critical ethnography was required to begin to understand the social organization of nursing knowledge and the ruling relations that influence ANS' experiences in Western Canadian schools of nursing. I

shared my intentions about this study with the president and executive members of the Aboriginal Nurses Association of Canada. I conveyed to others that I am not the expert on ANS' experiences; ANS and Aboriginal nurses are the experts with first hand experience in Western Canadian schools of nursing. By assuming the standpoint of ANS throughout the study and attending to the voices of the ANS, I explored and explicated the everyday lives of Aboriginal peoples in nursing schools, maintaining ethical quality.

4.4 Chapter summary

In this chapter, I explained that critical ethnography was the most appropriate method of inquiry to address the question: What are the social relations coordinating ANS' experiences? I used multiple sources of data: 31 transcripts about ANS' everyday lives, 5 transcripts about ANS' educational experience several years to decades ago, 24 transcripts from members of the nursing faculty, and 16 transcripts from key informants, field notes from 200 hours of fieldwork, and 135 texts. I incorporated aspects of Aboriginal epistemology, decolonizing methodologies for Indigenous peoples, cultural safety, and the social organization of knowledge into the research process. Using a computer software program to help organize the data, I used a three phase technique to analyze the texts (transcripts, field notes, and nursing texts, forms, documents), whereby ANS' experiences were explored, linkages with faculty's experiences were identified, and then ideologies were delineated. In the data analysis process, I focused on mapping how the everyday lives of ANS were coordinated and organized via texts originating from outside and inside the school of nursing. I explained how I maintained scientific and ethical quality throughout the project.

5 BECOMING A NURSE: THE STANDPOINT OF ABORIGINAL NURSING STUDENTS

Student #31: They should open up a nursing school for Aboriginals so it would make life that much easier (29).

5.1 Introduction

In the remaining chapters, I present the empirical findings of the research. Beginning with the standpoint of ANS, this chapter focuses on some of the experiences of ANS in two Canadian schools of nursing. Experience is the starting point to unearth how people's lives are socially organized (Campbell, 1998; D. Smith, 1987). In Chapter Six, I present ANS experiences from the standpoint of nursing faculty. In Chapter Seven, I provide a synopsis of the broader social context shaping ANS' experiences from the perspectives of individuals identified as key informants. In Chapter Eight, I map how the experiences of ANS are coordinated and organized by discourse within and outside of the schools of nursing. In Chapter Nine, I discuss the findings in relation to the theoretical and methodological perspectives guiding the study.

I analyzed transcripts from interviews with 31 ANS and 5 Aboriginal nurses along with our reflexive and descriptive field notes to describe: (a) the everyday/evernight experiences of ANS (the local) and (b) explicate perceived tensions between ANS and other social groups within the schools of nursing (the translocal). When I present the findings, I am not inferring that all ANS have similar experiences in all schools of nursing. The data was analyzed to explore diverse experiences of the varied standpoints of ANS in two Canadian schools of nursing. More to the point, the study was conducted to identify and describe social processes that had a generalizing effect – social processes associated with difficulty in recruiting and retaining Aboriginal peoples in nursing education.

The theoretical and methodological perspectives guiding the study also provided a template for my presentation of the findings. Relying on Aboriginal epistemology, I present the pathways ANS traveled to become a nurse. The beginning of the journey often occurred in the form of a young child's dream to become a nurse. As the child matured into a young adult, alternative pathways postponed the realization of the dream to become a nurse. Alternative pathways usually included becoming a parent and/or following a different or related career path. Guided by L. Smith's decolonizing methodologies for research and Indigenous peoples (1999) and cultural safety (Ramsden, 2002) as an analytical lens, I was awestruck with participants' determination, resilience, and personal agency interwoven into various scenarios whereby these Aboriginal peoples overcame huge obstacles and accessed opportunities to ensure that their dream of becoming a nurse became a reality.

Using D. Smith's social organization of knowledge (1987), I proceed with the actual experiences of the ANS in two Canadian schools of nursing. Findings presented in this chapter address this research question, "What are some of the everyday/every night experiences of ANS in Western Canadian schools of nursing?" I provide examples from transcripts and field notes that illustrate experiences of ANS and how ANS perceive tensions from other social groups.

To protect the identity of the two male ANS, I altered their comments to reflect the standpoint of a woman³¹. Identifiable features of certain stories were slightly altered to further protect the identities of participating ANS.

³¹ Although the committee and I acknowledged that gender shaped ANS' perceptions and experiences, we decided that protecting the identity of the two male ANS was the key priority.

I organized this chapter to reflect the long and arduous journeys that ANS experienced to become a nurse. The journey is divided into two phases: (a) the journey to the school of nursing, and (b) the journey *through* the school of nursing.

5.2 Becoming a nurse: A long and arduous journey

Many ANS shared stories about their personal journeys to become a nurse. Using major themes, categories, and codes delineated from the data, I describe how participants became interested in becoming a nurse and then I relay the actualities of ANS' experiences of learning to become a nurse. During this interview, the ANS shared the notion that all ANS required a longer period of time to complete the nursing program.

Ardelle: What factors have influenced your inability to participate in learning how to become a nurse?

Student #23: For me, it's the long road to stay that focused (p. 19)...I haven't met anybody [any ANS] yet who has done it [the nursing program] in the 4 years, though. It's always been longer (p. 25).

5.2.1 Journey to the school of nursing

I now describe the empirical findings that reflect the ANS' journey to the school of nursing, including excerpts from transcripts and field notes that illustrate how these Aboriginal people became interested in becoming a nurse. Beginning with a childhood dream and hopes of making future life better for themselves, their children, and their peoples led ANS down the path toward a school of nursing.

5.2.1.1 A dream to become a nurse

The journey to the school of nursing often began in early childhood with a dream of becoming a nurse. Many ANS explained that in their memory, they had always dreamt of becoming a nurse.

Student #30: I have always wanted to be a nurse. I don't know how, but I remember in Grade 2 when I wanted to be a nurse (p. 1).

For several ANS, the idea of becoming a nurse was not brought to the forefront of their minds as self-doubt was experienced about their cognitive abilities to learn nursing.

Student #6: I knew in the back of my mind I always wanted to be a nurse, but I thought I wasn't smart enough (p. 2).

In contrast to always wanting to be a nurse, one participant was keenly aware of others' expectations that she would grow up and provide health care to Aboriginal peoples in some capacity. This participant pursued nursing education for the purpose of acquiring the necessary licensure to provide health care to Aboriginal peoples.

Aboriginal Nurse #4: Well, I have always been in medicine. I was identified early in life as a medicine woman, and was expected to perform that function in society... So it was always an expectation of my community that I would be in medicine and it was just a matter of getting the right papers so I could practice... It was an expectation; it was my name from the time that I could remember, the nurse, not the nurse but the medicine woman or medicine girl (p.4).

The dream to become a nurse was sometimes followed by observations of nurses or family members who worked in health care positions. Some ANS explained that nurses in their community were positive role models that encouraged Aboriginal youth to plan for their futures. Aboriginal nurses were proof that being a nurse was achievable. As many First Nations communities suffered from rampant rates of unemployment (as high as 80%), Aboriginal nurses explained to youth in the community that gainful employment was highly probable.

Student #25: That was a long time ago. Probably when I was in my elementary years, I just, I was just fascinated by the way the nurses were working with young people and Elders (p. 1).

As health care consumers, several ANS interacted with nurses. These positive experiences with nurses stimulated the idea to become a nurse.

Student #7: My father was sick and died of cancer and I had interacted with the nurses on the palliative ward and I found them to be very nice and knowledgeable and it just made me feel like I wanted to become like a person to help other people out (p. 1).

In contrast, some participants had negative experiences in health care facilities. These ANS became interested in becoming nurses because they were determined that as nurses, they would deliver more appropriate and sensitive care.

Student #11: I think the thing that really influenced me most to be a nurse was just when I take my child to the hospital. It's not that me or my child have experienced bad behaviors from nurses. But just hearing nurses talk about other patients and then treating other patients this way. Well, if you are like that, why are you in this profession? You should be enjoying your job. You are supposed to be helping these people, nurturing these people - physically, mentally, emotionally. And you are like it's just become a job to them. It's not. They are forgetting the emotional aspect of it and not really helping these people (p. 12).

5.2.1.2 Making a better future

Future employment as a registered nurse would facilitate the provision of a more economically stable situation for these women and their families. The stigma of living as welfare recipients was painful and degrading. These women wanted to be able to provide a better future for themselves, their children, and their communities. Becoming a nurse would allow these women to engage in a fulfilling and meaningful career coupled with the financial benefits. The economical bleakness in First Nations communities was discussed with the realization that a nursing position in a First Nations community would be a viable option to make a better future for themselves, their children, and their peoples. Making a better future for families was a major motivator in ANS' perseverance to succeed in the nursing program.

Aboriginal Nurse #3: So I'm telling you like I said to myself, I am going to be a nurse if it kills me. That's the drive I had and I remember I am going to get off of this welfare business and I am not going to be on welfare because I hate it. It is degrading. I am going to be a nurse. And I am going to do it if it kills me and I did. I was really happy after I graduated and I got a job and I was making money and I was off social assistance completely and supporting my family (p.8).

Student #19: After living up north in an isolated community for so long it seemed like there was nothing I could do like get a job. I could have just stayed and sat on welfare the whole time but because [the northern nurse] said that to me [you can go to school and help us and be a nurse here] that's when I thought you know, ya I could, and I could help them and it's not that hard (p. 1).

The future prospect of being financially independent provided ANS with the hope that they would have the ability to provide more nutritious food, clothing, housing and recreational activities for their children. Dependents and partners supported the notion that becoming a nurse would make life better for all members of the family.

Student #10: ... They [nurses at the nursing station] said it was nursing and then all these things they said, "You will never run out of food. You will have toys. You will have like..." (p.4).

Student #18: They are proud of me, they are, they are, and I told them like I get them motivated, kids if you want to spend your vacation in Florida, then get those dishes done... Okay mommy, and they get the dishes done, ... maybe I could take them to Disney World some day (p. 20).

Several participants identified that they only enrolled in nursing to ensure that they received Band sponsorship while they were waiting to access other forms of postsecondary education in other fields. An ANS decided to apply to the school of nursing when she heard that entrance requirement for Grade 12 mathematics had been lowered in nursing, capitalizing on an opportunity.

Student #26: I took a health education program which was to enable us to learn about health profession courses, but my main interest was pharmacy and going into research after pharmacy but and then nursing happened so I took the nursing course because a lot of the courses were the same as the entry courses for pharmacy, so I have been on a 3 - 4 year waiting list and this is my second year on the waiting list (p. 1).

Student #22: In deciding what career I should go into I overheard a student at X adult education program that they lowered the math pre-req for nursing, so I thought well, that's within my grasp. I may as well check it out (p. 1).

These participants chose nursing for two important reasons. Firstly, they were provided with (albeit minimal) funding for immediate survival. Secondly, they viewed

their stint in nursing education as a temporary route to other fields that would ultimately serve to provide a better future for themselves, their families, and their peoples.

5.2.1.3 Alternate pathways

Many of the ANS were mothers, who decided to enter into a nursing education program after having their children to make life better. Being more mature and having diverse life experiences motivated ANS to pursue their dream of becoming a nurse.

Student #5: I have always wanted to be a nurse, right from when I was a little girl and just life circumstances – I wasn't able to. I have three children (p. 1)...So my goal was after my youngest got into school full-time, that I would go into nursing (p.2).

Life circumstances and experiences promoted self-actualization and thus, ANS were more confident that their dream to become a nurse was achievable. Some ANS entered their nursing education after working at "dead end" jobs or having to experience the degradation of relying on social assistance. Self-confidence gained through life and work experience facilitated the process of applying and entering into a nursing education program. Successes elsewhere provided ANS with the self-confidence that they indeed had the capabilities to succeed in a school of nursing.

Student #6: So then I took a first aid course and I was basically the only one who volunteered as a first aid provider for many years and it was a community of about 500 people so I thought after ten years, "I really, I am smart. I like this. It's time for a change...Maybe I should be getting paid" (p.2).

5.2.1.4 Substandard education on reserves

Twenty-seven of the 36 ANS and Aboriginal nurses (75% of the participants) identified that they grew up living in an Aboriginal community or reserve. These ANS were plagued with a huge obstacle, substandard primary and secondary education. Children's education in primary and secondary schools on reserves was perceived to be substandard to schools elsewhere. A Grade 12 education on a reserve was equated

with a Grade 8 education in an urban centre. The inequity between reserve and off reserve education was a taken-for-granted actuality.

Aboriginal Nurse #3: And right away I felt, the word I would use is that I felt intimidated, maybe because these girls were all young and they were smart and right out of school, and they were getting good marks right from the start, you know, and my marks were just passable, I found some of these courses difficult because I had been out of school a long time and when you grow up on a reserve you don't get the education that other people get when they live in the city. Where their education is top notch, that's what I call it. When you are on a reserve, you don't get, your education is not as advanced, I think as others. So anyways, I struggled along with everybody else just getting passing grades and mind you on the physical part of the nursing, I was terrific... But you also need the theory part to pass and to become a good nurse you have to know a lot (p.2)... I took a short upgrading course, just to upgrade my skills because I have grade 12 and a lot of this I forgot, so it was great that I did that. I took some English and I took mathematics that helped. But yes I agree with that, the education on the reserve is the poorest (p.5).

Even by successfully completing a Grade 12 education, several ANS from First Nations communities described how they observed other Aboriginal students' failure at postsecondary education. Their predecessors' experiences influenced these ANS' decisions to stay in their home communities to complete a "transition" year to up-grade prior to pursuing a nursing education.

Student #10: I need to be here in the city with all the extra...technology, resources, the extra stuff that they may know that I may not know... Well, I do know for sure that in the city you get a lot better education, which is why probably you had to do the prep here because we don't have the chemistry. We don't have the biology offered in high school, so where at the challenges?... It seems that everyone is more advanced in education that they have had the opportunity to already challenge themselves in high school. So here it's kind of like, well it's going to be kind of the same thing. But for me, it's a big leap. Work harder, that much harder. I know you have been working hard but... So when I ask people sometimes you know you ask people or a person a question and they say, "You don't know that! You should know that (p.7)."

Another participant described how being educated on a reserve and having English as a second language negatively influenced her self-confidence in pursuing a nursing education. Other ANS and Aboriginal nurses inspired her.

Student #20: So I applied for [the access program] and I got accepted through the school but I couldn't get into nursing yet. They were eventually you will get

accepted, but I just took [access program]. I wanted to be prepared. Because I thought I wasn't ready. I wanted to upgrade – more math and science (p. 1)....I kind of was overwhelmed with all the courses. I was thinking coming from a reserve – I was kind of doubting myself. I grew up on a reserve and I really doubt myself because English is my second language and it was kind of, I was kind of overwhelmed by that and I started seeing other students, Aboriginal students, meeting Aboriginal nurses and I was kind of inspired by that too (p.2).

Several participants did not have a grade 12 education. As mature students, the access program facilitated their abilities to upgrade their knowledge requirements and related skills to pursue a nursing education. Lacking a complete secondary education created self-doubt.

Field Note (7/10/04): She had a Grade 10 education and up-graded. She found school very hard. That is a common reoccurring theme – the limited education that they begin their programs with correlates with their confidence level being low. She made the comment that no Aboriginal person has completed this program in four years. We talked about Aboriginal parents long ago and how their expectations weren't that you graduate and seek a profession. But rather that you help the family live. She said her dad worked to feed, shelter, and clothe her family and when she was old enough to help, "I quit school and helped him on the farm."

5.2.1.5 Transition and/or Access Programs

Many ANS traveled alternate pathways and were hard pressed to believe that their dream could come true because of substandard education in First Nations communities. Because many Aboriginal peoples lacked prerequisites to enter into postsecondary institutions, these participants capitalized on available opportunities to prepare for postsecondary education in the form of available programs in First Nations communities and/or access programs at postsecondary institutions. Transition and/or access programs provided ANS with prerequisites to enter into their nursing programs.

Several participants were categorized as "mainstream" students as they did not enter into the nursing education program via a transition and/or access program.

"Mainstream" ANS experienced more difficulty finding academic, personal, and financial resources. These ANS seemed to fall between the cracks in that resources available to

ANS in access programs were unavailable to them. "Mainstream" ANS had to actively seek other campus resources such as financial support, tutorials and personal counseling.

Ardelle: Can you tell me how you are funded to study nursing?

Student #21: Through the employment training services. So they have paid 75% of my tuition and books for the first year and then I am receiving employment insurance. So far [it's enough to live on] so I know it's going to get tight because I had saved a lot of money before I moved [to the city] so I think by Thanksgiving, it's going to be getting tight because I am getting \$600 every two weeks from employment insurance and my rent is \$900 a month (p. 4).

Ardelle: What factors have influenced your inability in learning how to become a nurse?

Student #21: Stress and money and parenting. That's probably it.

Ardelle: Do you have support at home with your children?

Student #21: It's just me and them [my children] here but my grandpa lives in the city and an aunt. The rest of my family is up north. There is the phone so we are phoning home quite a bit. Childcare's been good. I was able to get my children into the daycare that's on campus and it is subsidized through there so...I don't know if I'd be able to handle them being across the city in a daycare while I'm at school...Our bus comes by at seven. We are up at 5:30 or 6...Throw them in daycare, run to my classes and then... (p. 5-6).

Participants also identified that personnel within the Access Programs were important resources to them in their journey through the school of nursing. ANS' experiences in Access Programs will be further discussed on page 143.

5.2.2 Journey through the school of nursing

The journey through the school of nursing was lengthy with many recurring obstacles along the way. For many ANS, upgrading their education was required to ensure they acquired necessary prerequisites to a postsecondary education. Thus, a four year nursing program actually became a minimum of five years for many ANS.

Student #12: Two years ago, it was kind of funny because I was in the [preparatory courses] and it was like, "Oh, I am a nursing student." [Someone asked], "What year are you in?" [I answered], "Well, I am not in a year yet, next year I will be in year one. I am in year one of a five year program." That's what I tell people all the time. They are like you are in the four year program? "No, I am in the five." [They asked], "What's the five year program?" (p.27).

I organized ANS' descriptions of their experience under headings that reflect the trajectory of their tenure as student nurses: (1) culture shock, (2) informal and formal supports (3) intersectionality of gender, race, culture and economic status, and finally (4) the journey's end. "Culture shock" denoted the initial experience of entering nursing education at an urban campus. By using informal and formal resources and upon readjustment to the urban lifestyle and large campus, ANS experienced a relatively smooth ride through first and second year nursing.

Informal and formal supports were necessary features to ensure a completed journey. ANS' personal agency was a crucial component in ensuring completion of the journey. Sharing experiences with other ANS enhanced student's abilities to cope with various challenges. Academic support was greatly appreciated. ANS felt connected and supported when nurse educators demonstrated an understanding of Aboriginal culture and life on a reserve.

I used the phrase, intersectionality of gender, race, culture and economic status to capture the essence that aspects of ANS' experiences were directly or indirectly associated with the collision of being Aboriginal women juggling multiple roles and childcare in poverty. This intersectionality or collision created double, triple, and quadruple jeopardy for ANS. I identified that personal issues, lack of social support, lack of available childcare, ethnocentrism, racism, conflicts with teachers and the major obstacle – inadequate funding were associated with intersectionality of gender, race, culture and economic status. These issues were greatly shaped by the historical and sociopolitical context. Finally, I present the ANS' descriptions of the journey's end as ANS exited the schools of nursing in one of several ways.

5.2.2.1 Culture shock

"Culture shock" best described how ANS' experienced relocating to an urban centre and beginning their nursing education at an urban campus – through an unknown, new, and fast-paced world. ANS described their initial feelings of being intimidated and overwhelmed in a city and in the postsecondary institutions.

5.2.2.1.1 Adjustment to urban lifestyle

Many participants were required to relocate to an urban centre to acquire a nursing education. These ANS spoke about their experience of culture shock as they tried to acquire housing, childcare, and transportation to and from school in an urban centre away from their extended families and friends. These ANS were required to readjust their lifestyles to accommodate the proximity of many busy people and use public transportation to travel to the postsecondary institution and clinical placements.

Student #11: From high school I was a keener so it was easy at the academic point but transferring from rural area to urban area was very, very tough for me like I wasn't, I was not used to it at all. It took me a long time to adjust. Like I was stressed. I was, I guess, cranky and stuff like that just because I don't like city life even now. It's just I can't stand it. It's too stressing, too much. It's convenient but it's very, very stressing because you have so much more that you have to pay for financially and it's hard (p. 2).

The next excerpt depicted the complexity of the entire family adjusting to a new world with limited resources and loneliness in a society laden with negative stereotypical images of Aboriginal peoples.

Student #27: It's really tough. Especially when you have little ones you know. It's not only a transition for myself personally, but my family as well, like we struggled to find a place to stay and a place to call home. Like stability was a problem. And especially my children – they are still, like we have been here for about two months and they are still you know adjusting to the city life compared to at home where they can go out and run around and you know everybody watches everybody's kids and it's just...and the neighbors cause a lot of problems, too so (p. 3)...as we speak, I am looking for childcare for my children because my husband needs to find a job, right? So we are looking on finding daycare... Yes, I am just terrified to leave [children in the care of strangers]. I am actually thinking of begging somebody at home to come stay with me for awhile,

but I don't know if they will cause it's a big difference (pp. 10 – 11)...I think there is a lot of stereotypes in the city...Especially where as I explained to you, I wasn't even in my townhouse for a week and a social worker is knocking on my door, you know, like what is that? Like there is, my mother is phoning me and saying, "OH F them and don't worry, my daughter. You know there is a bunch of A holes that live around there." And she was furious...I have dealt with racism you know, I have been called primitive and savage but never have my kids been used against me and...it was tough, you know. I felt terrified. I was mad...It was like if you talked to anybody at home, they would say, "Well, she never goes anywhere. She is home with her kids all the time." You know cause that's true. I never leave my kids since my son was a baby because I breastfed him so I never left him and just for that happening here, I wanted to run home (pp. 25-26).

5.2.2.1.2 Adjustment to urban campus

ANS described their initial experiences within the school of nursing as being overwhelmed and intimidated by the numbers of students unknown to them, the speed and amount of information provided to them, and the challenge of communicating in English as a second language. Campus size and the lack of Aboriginal peoples in the overall student population were identified as intimidating factors.

Student #27: Oh, the classrooms – they are so huge. The first couple of weeks here I was so overwhelmed and nervous because of the people – there were so many and so little space. It's like you are invading my aura in a way (p. 7)...I was just sitting there and hiding and like I have never had so many people sit around me, like behind me and I just get the chills and it's awful (p.8).

Student #23: I felt strange cause there weren't many Aboriginal people in my classes and also it is such a big place, compared to, you go to high school and it's basically you walk around once and you are done. And here there are so many different buildings (p. 3).

5.2.2.2 Informal and formal supports

Informal and formal supports were used by ANS to enhance their journeys through the school of nursing. As formal social support networks or mentorship programs were not established, ANS described their sources of informal supports as themselves, other ANS, Non-Aboriginal nursing students and Aboriginal nurses.

The most frequently cited formal support was personnel in the institutions' access programs. Twenty-one ANS entered nursing via access programs. Access programs and their personnel were described as positive and supportive. Another helpful resource was the availability of additional tutorials. Unfortunately, most of these free tutorials were only available to access students. ANS who entered schools of nursing as "mainstream" students lacked these important academic resources.

5.2.2.2.1 Personal agency

I used the term, personal agency, to describe the internal power and strength exhibited by many ANS. To safely journey through schools of nursing, ANS relied upon their personal agency. ANS originating from urban, rural, or northern settings used their personal agency to "work" the educational system and "manipulate" the related bureaucracy to their utmost advantage. Assertiveness, ingenuity and relentlessness were used to acquire a nursing education despite the odds against ANS. Aboriginal nurses and ANS described their perceptions of situations occurring in the learning environment and their subsequent assertiveness with Non-Aboriginal students, nursing instructors, staff nurses and physicians.

Student #22: I actually told an instructor she tried to yell at me and call me incompetent over a journal that we were supposed to do, a clinical journal. And I said to her, "On what grounds are you calling me incompetent?" And she was talking to me like I was 12 and she said, "You didn't hand in your journal and you didn't bring your paper on time." And I said, "Well, first of all, the journal is a no grade paper." It goes toward the whole picture but I still had to hand it in. I got zero on it. And then the second thing with my paper was a day late, so I was docked 10% and I thought that was penalty enough. I didn't need to hear from her as well, saying that I am incompetent. So I basically told her, "I don't appreciate the way you are talking to me. I felt like you are treating me like I am 12. I am 30 years old." (p.5).

Some ANS utilized their political savvy to access allies to help in advocacy during situations where they experienced problematic student-teacher relationships or

inequities in funding rules. These ANS voiced their concerns and then conducted follow-ups to ensure that these “advocates” addressed their concerns.

Student #9: So I went and talked to my MP. We connected, she, I told her my story and what I do and wherever money was at and all that stuff you know, and that I was only going to get a certain amount of money and she contacted Student Loans about my vehicle and all that stuff, and her assistant took all my information down and they rejected me because I appealed it and they rejected me. So then the student aid gal that comes here – she is really nice. She felt really bad because she is not – it’s just the committee that rejected me. And I wrote everything that they wanted – I gave them and all that stuff so basically my MP contacted them and they said no and all that stuff, like it’s you know, and then she said that how about a reporter from parliament call you and I said well that’s fine she can call me and ask me questions right? So then she called me and I gave her my information and then the next, not even, then she called me back and she said if Student Loans don’t call you in a couple of hours call me back tomorrow. Then the Student Loans personally phoned, called me and said that they approved my appeal (p. 12).

Many ANS explained how they used their ingenuity to access available resources and maneuver themselves within the educational system. They devised ways to make the system work to their benefit when faced with obstacles such as a lack of resources (i.e. funds for textbooks) and ethnocentrism.

Student #22: I found out ways to buy, to cheat the system, and one of the things that I would do is as soon as I would go to a class I would find out what textbooks they had, like the first day or prior. And I would go run to the library and take out the previous edition or sometimes the library here is really good and they will have the latest edition, and I would just keep renewing them until the term is over which you can do (p. 3).

Aboriginal Nurse #1: Actually I took a course at the [Canadian university] on how to study and you learn how to read your professors and you know what they want you to learn by looking at their syllabus and so you learn how to give people back what they want and you learn to which professors will allow you to disagree and so you learn how to give people back what is necessary for you to pass your grade. I’ve also learnt that I can do that and not agree with it inside. I know on paper if I disagree with it I won’t pass. So I give them what they want. But I know in here what I believe; what my belief systems are. I was older when I went back to [the Canadian University] so I had 2 children, I was a single parent at that time so I was growing to the point where I could do that. If you have a young 19-year-old person that goes to university and takes the professors as god and their word as the truth then it’s hard for them to do that. To know that it’s a system and an institution that needs some way of a pass/fail thing and so you have to learn how to do that in order to get your degree (p.11).

An Aboriginal nurse³² perceived that in her experience as a student nurse, she was not allowed to employ culturally appropriate community styles by sharing information about her community of origin with an Aboriginal patient. She described how she continued to communicate to Aboriginal patients in a culturally appropriate manner. As a student nurse, she documented a "bogus" interview to appear that she conformed to the teacher's expectations.

Aboriginal Nurse #4: Well in the clinical portion, if I walked into an interview with a client, potential client, I would introduce myself, my place of origin, my family heritage, and then my professional capacity. I would ask the client the same, in the same order, what their family origin was, and their place of origin was, and establish heritage. If you ask a Native person how are you, they answer on a spiritual or on an emotional level, even if they are dying, even if they are in great pain, you ask them how are you, and they will say fine, because they are answering from a spiritual perspective or an emotional perspective rather than a physical perspective...So that got me in trouble, because I wasn't supposed to be subjective, right?

Donna: You are supposed to follow exactly the protocol for whatever the interview guide is given?

Aboriginal Nurse #4: You say your name and you are a nursing student, and you are here to do whatever, to assess your physical body.

Donna: Yes.

Aboriginal Nurse #4: Or perform a physical function. Whereas, in a holistic sense, in holistic medical model, you address first the spiritual person, the emotional person, and then the physical is last, always last. Unless somebody is bleeding or having a hard time breathing, it's just the way it's done, you go around the whole physical portion and you let them tell their story and even if the story starts 40 years ago, you let them tell their story, because they are going to get to the point and you get a better understanding of how they got to that point.

Donna: Can you tell me a little bit more about how that got you into trouble?

Aboriginal Nurse #4: Well I had to do, we had to do these interviews, write all these interviews out, and then you had to have somebody watch you do an interview or you had to have somebody watch you do an interview and then you had to write the interview out. So when my instructor came to watch me do the interview, then she said, no, no, you don't tell people where you are from and who your family is and ask them who their family is. You are being, you are

³² Please note that I originally recruited Aboriginal nurses to acquire a sense of past educational experiences of ANS. However, these nurses provided me with rich descriptions of the social relations occurring in their educational experiences. As these participants already graduated and worked in various health care settings, the committee and I chose to use their quotes whenever possible to illustrate important features of ANS' experiences. Although I strived to protect all participants' identities, I was keenly aware that ANS might be vulnerable to a "backlash" in the participating schools if they were identified. We concluded that Aboriginal nurses were less likely to experience a "backlash" as they were already established in their worklives and in professional nursing associations.

placing yourself in a subjective position and you are straying from the point, which is the physical, right. Just because this person had gallbladder surgery, you don't have to know who their family is, you don't have to know where they are from, and I disagreed and I said I can't be that objective; I have to know, establish first, heritage and place of origin. So then I started picking people who only spoke [my Native language]...And editing my interview accordingly...I did play the system. And that's what I did. I just picked people who spoke [a Native language] and did my interviews in [the Native language] and wrote them out in English the way that they are supposed and then, it seemed to me as I was writing out the interviews, that I was starting at the end and not at the beginning (p. 8-10).

The majority of ANS was greatly determined to succeed in their nursing programs. They described how they persevered despite problems.

Ardelle: What are the things that might encourage you to keep studying in this program?

Student #21: I think basically myself. Like I have set my goal and nothing is going to stop me from getting it (p. 3).

Student #9: And I have a big family so, and where I came from and how I was brought up and you know then I know I am able to do certain things because that's just how I am. And I know when to, like if I don't know it, then I will ask for help and all that stuff too so yes, cause I don't want to fail. Obviously I am not going to get everything right all the time and I know that too and all that stuff so I am able to ask questions and all that stuff so I am able to approach somebody and say you know this is, I need some help, and you know...You know like it takes a lot for me to go down. You can't knock me down because I try to stay...afloat and you know I will just work harder and harder to ...If I have to work more – I will work more. If I have to like, my children have to be apart from me, then I am not going to stop that. A lot of people look at – there is some people that judge me because of my time away from my children...I have to do what I have to do to take care of my children (p. 19-20).

Additionally, ANS identified their personal growth during their preparatory year and/or throughout the studies in the nursing program. ANS described how they discovered and were more comfortable using their voice.

Student #10: What's even better now is that I am opening up to people and asking them about resources, whereas, before I was pretty much mute you know. I just want to get on with my studies, and so, but I realized that talking with people and trying to find resources helps a lot. I know it is extra work but you know in the long run it really helps (p. 11).

Most ANS soon realized that it was necessary to seek feedback from clinical teachers half way through their clinical placements. By actively requesting feedback from clinical teachers, these ANS sometimes acquired clear information about their clinical performances such as areas that were evaluated satisfactorily and specific skills that they needed further practice. Seeking and acquiring clinical teachers' evaluations earlier in clinical rotations provided ANS with necessary information about areas to improve in order to pass the course. The initiative to actively request feedback prevented the surprise and stress of having clinical teachers provide the ANS with a failing grade. Failing grades not only meant repeating the clinical, failing grades negatively influenced funding.

Ardelle: How do you ensure that you are going to pass your clinical?

Student #17: Usually half way through I ask them to just give me a little bit of feedback. If they think that there is places I am lacking, and if there is, so I can improve on it before the end and that's about it (p. 7)...And sometimes I ask – I just wasn't thinking appropriately, and then some of the laboratory instructors would make comments or rude comments so that was really hard. I walked out. I confronted the instructor and I said, "Forget it then." And I left and she followed me and the instructor didn't realize that she was making me feel like that, but I told her how do you think? (P.9-10).

5.2.2.2.2 Social support

The journey through the school of nursing was smoother when ANS accessed social support. Sources of social support were predominantly other ANS. Other sources included Non-Aboriginal nursing students and Aboriginal nurses who were identified as "informal" mentors.

Student #5: I think for me, I get my inspiration from the other students – Aboriginal students. That is a big push for me (p. 9)...I think the other students were a big support to me too, just helping me out and going through the first year (p. 19)... I usually, I'm usually pumped when I come home from school especially on clinical or if I have learned something new and I tell my partner and try to tell my family but they don't really care. They don't really want to talk about all that stuff that you are using, so I call my [nursing] friends and usually after each

clinical ...and I talk to them and we talk about how our day went because you can tell them all this stuff and they are so, they want to hear about it (p. 28).

Some ANS identified that they would seek and receive social support from family and/or members from their home communities. Having a "distant" shoulder to lean on would make the journey through the school of nursing smoother. If possible, family and community members also provided ANS with resources such as childcare, fresh food, and support for further funding.

Student #7: My family is my major support. My fiancé, he is like always pushing me and my kids and other family members, so they are like my main supporters (p. 3).

Student #16: My cousin, like the one that helped me move, well not move but she was the co-signer of my apartment and she was the co-signer for my student loan and she wanted to like do that for me... Yes, I have good supports (p. 33).

Aboriginal Nurse #1: And I had a lifeline to the community and I used to get fish and my mom and dad would send me potatoes and stuff out of the garden and this and that, so we ate fairly well (p.13).

5.2.2.2.3 Access programs

Of the 21 ANS who utilized an Access program to enter into their nursing education program, all voiced that they experienced academic, personal, and financial supports that helped them proceed on their journey through the school of nursing. Personnel employed in the access programs provided ANS with a sense of community and a place to go when they needed to talk to someone about their educational experiences in a student-focused manner. ANS expressed that "once an access student – always an access student." An increase in human resources in these departments was recommended by several ANS in that access personnel were perceived to be overworked and busy with other students' needs.

Student #9: I talk to my counselor at the access, my student counselor, my advisor... So I vent to her, you know if other things happen and all that stuff (p. 23)...I utilize Access because I took stats last year, so I got a tutor right away...I

would just use Access because it's free. It's because I am part of the Access program, so they pay for it, so why wouldn't I? (p. 27)

Student #7: I felt if I had any questions at all that I could just go directly to them [Access] and the main thing with them is that they knew me as a person whereas now, I am just a number, that's how I feel. Like there is 100 people in my class, you know and they don't know me on an individual basis (p.3).

Student #31: [The Access program] have supports and that and they provide supports to, well they provide supports to all the people... So they provide you with a lot of support. There is someone who is in charge of filling out forms for daycare, you know just little things that just add up and can become very serious problems. Student loans, there is a counsellor if you need to talk to someone if you are having problems they deal with a lot of issues and there was a Sharing Circle, and there was some you know cultural involvement there, there weren't only Aboriginals there. There were people who had come from Africa and stuff like that as well. So they are really supportive in that area (p.10).

5.2.2.2.4 Academic resources

Access students voiced their gratitude for tutors that spent extra time with them to assist them in their learning. As needed, free tutorials were offered to ANS in the access programs while other ANS were required to seek and pay for these services elsewhere on or off campus. ANS viewed nurse educators that were empathetic to Aboriginal peoples and communities' strengths and struggles as supportive. Taking extra time to explain the nuances of a clinical area and step-by-step processes of nursing skills were highly appreciated. ANS identified that most nurse educators and some "buddy" nurses were positive role models and an inspiration to them.

Student #6: Like if I had a problem in math, I could go to the access and see X and she is like, 'Oh, come sit down.' If I had a problem in science, there was somebody for me (p. 5)...[The clinical teacher] was great, she was very supportive and I had a patient who wanted, was talking about committing suicide, you know her husband had left, her child didn't want her, and that was my first clinical, like oh not, what do I do? And she sat me down and she said, "Okay this is what we can do." And then came into the room with me afterwards when we went back and supported, exactly...And that's all I found from her was support and so even now, I can walk into her office and say you know, "I have a slight problem." And she'll either help me or steer me in the right direction (p. 13).

Student #5: Well I am at [hospital] now and the nurses are so nice and the teachers really, she's taught up in the north in [town] and [town] and I just feel

like she has more of an understanding of us and my group has more Aboriginal girls in it too... So I feel that she has more of an understanding of our circumstances and I really like her... I feel supported by her... I was doing my research the night before and didn't really understand what I was looking for in diagnostic tests and she took the time and sat with me for about fifteen minutes and just gave me really good pointers on how to read the diagnostic tests fairly quickly and try to ... She is going to be really good... And I got that feeling as soon as she told me where her experiences were and that she is just new to the city and I thought that she must have a little understanding of you know, working with Aboriginal students probably and she is, she is really, really great (p. 29-31).

5.2.2.3 Intersectionality

I use the term, intersectionality, to describe how gender, race, culture, economic status, and geographical distance from social support systems were forms of oppression that magnified one another (Young & Paterson, 2006). For example, being racialized is not an added form of oppression for an impoverished Métis woman; rather it heightens or magnifies the oppression (Young & Paterson, 2006). Intersectionality of these variables created undue stress that affected many ANS' ability to focus on learning how to become a nurse. Factors associated with the intersectionality of these variable were identified as personal issues, lack of social support, lack of available childcare, ethnocentrism, racism, conflicts with teachers and finally, the major obstacle – inadequate funding.

5.2.2.3.1 Personal issues

Thirty-four of the 36 participating ANS and nurses were women. Gender shaped a significant portion of these complicated experiences within their personal lives. For example, some participants described their reactions to an unplanned pregnancy during their tenures as nursing students.

Student #5: I got pregnant in the first year of nursing so I had to see somebody [a personal counselor], because I was like, "Oh my God! Here we go! Here's my plans completely ruined" (p. 11).

As with many adult learners, perceived or actual crises in ANS' personal lives created additional stress that negatively impacted on the students' ability to learn new knowledge and skills. As 25% of participants were single parents, the burden of multiple roles influenced their inability to focus on learning. Providing an income and childcare became their priorities as survival was paramount rather than studying.

Student #2: The reason I didn't [pass a third year course] last year - I was away for two weeks. And during that time, you missed a lot and you try to catch up... But my son... he wanted to commit suicide because he was diagnosed with kidney failure. He said, "Mom, I'd rather not live." We had the police involved. My brother had to come in for a month. My husband took time off work. We basically spent time with my son and we tried to get him better (p. 14).

Student #10: Only now things are kind of like working against me, it seems and like I expected these kinds of things to happen and a lot of it is personal stuff. A lot of it is family and a lot of it is... I think it is a bit of everything - your studies, your family life and the fact that I was going through court to try and get [custody of] my two daughters. They are over there and there was a lot of personal things and I think it finally caught up to me like I try to be strong about everything and trying to be you know on top of things... So then it gets to the point where your body just can't take anymore and it's like arghh (p. 14-15).

5.2.2.3.2 Lack of social support

Lack of support from partners, family, fellow students, friends and residents of students' home communities was described as a factor that fuelled ANS' lack of self-confidence in acquiring a nursing education. The intersectionality of gender, race, culture and economic status along with the necessity to relocate to an urban center shaped experiences of loneliness. With limited financial resources, long distance telephone calls to acquire support from extended family members were prohibited. This excerpt illustrated how gender relations sometimes influenced a lack of social support.

Student #19: I had a bunch of friends quit [nursing education] because of their boyfriends - they are not supporting them and their boyfriends are jealous that they are making a better life for themselves (p. 30).

Some ANS perceived that they were treated as outsiders in their home communities. ANS explained that they were considered outsiders because of their experience away from the community in "white" postsecondary institutions.

Student #7: I guess sometimes it's just like friends because I like to when it comes to homework and assignments and you know you want to talk to someone about it. People just aren't there. They are like too busy with their own lives. They don't help...I just feel like sometimes, some days, I just feel like a total loner. I am singled out and you know no one wants to be my friend. And that I am going to have to do this all by myself...Some of my friends like they don't have kids so that plays a big role. They don't understand what I have to go through (p. 11).

Student #1: When I go home, everybody's like, "Come on, let's go drink," and I'm like, "No, I have to study or something," and they think I can do that later and they don't really understand the demands of being in school. That's pretty much all I can say about them...They say I sound white now, that I lost my accent but I don't know like how can you sound white? But apparently, I do (p. 10).

5.2.2.3.3 Lack of childcare

ANS with dependent young children struggled to locate accessible, reliable, and affordable childcare. Before and after school programs, as well as infant and toddler spots were difficult to locate and acquire. In particular, programs that opened early in the morning and late in the evening were lacking. Accessible, reliable, and affordable childcare programs were needed to accommodate ANS' attendance at their early morning clinical placements. In addition, financial resources for costly childcare were grossly inadequate. At times, the consequences of ANS' inability to access children were severe. Sometimes, ANS chose to temporarily dismantle their families and send their children back to home communities where childcare was available. In some instances, children under the age of twelve years were required to be home alone while their mothers were required elsewhere in clinical placements or at the postsecondary institutions.

Student #22: We couldn't get him into a daycare spot so now he is living back with his grandmother temporarily until we can find him childcare. That was stressing me out big time, what to do with him. I don't know and then my 8 year old. What to do with him before and after school. Daycare was full...Yes and costly. And so he is 8 and it is about a three block walk from his school to our house, so I reluctantly told him that he could start walking home from school, mapped out the walk for him and everything and told him what to do in case someone approached him and whatever, gave him the whole spiel about strangers and stuff and just prayed that nobody bugged him or would bother him and he was walking home and then my partner would have to leave his job...and I just prayed that he would get home in time for my son...because he takes the bus, too (p. 23).

Student #11: And daycare doesn't open until 7. Probably every daycare in the city opens at 7. Well, what am I going to do with my child...It's a lot of juggling around. It's my sister works nights, she works night shifts, she comes straight to my place from work and a lot of time, like my daughter is 10, but I have had to let her remain there, an hour, half an hour or so alone just until my sister gets there, like even though they say, "Oh you can't leave your kids alone." Well, there is nothing that I can do. And it's not like I am just going to go to the neighbor – "Can you watch my daughter this and that?" which I have done, but then the money thing comes into play. And then they want money, and then they want more money and I have given them, but there is only so much that I can give (p. 8).

Student #1: I think that's where I had the most struggles with was in clinical just because it was hard to get a sitter. To be somewhere at 7:30 in the morning and I really struggled with that and I had a lot of conflicts with my clinical teacher, not just one of them in particular but all of them because of lack of communication and that's where I lost the majority of my marks was for poor communication (p. 6-7)...[A clinical teacher] even offered her babysitter to me...Yes, that's what they wanted because I missed one time and it was because my son was sick and they kept telling me, "You should have a back-up." And I tried to tell them that I didn't really know anybody yet. This was my first clinical and I didn't know anybody and I'm not going to leave my son to go to clinical when he's sick. I don't know what to say...maybe some people feel comfortable leaving their kids but I don't (p. 8)...So I was late for my clinical course every time because she wanted to start at 7:15 and I couldn't because my daycare didn't open until 7. So I lost marks for professionalism along with my communication. I only got a C+ on both of my clinicals and that's where my marks are the weakest. I'm getting As and A+ everywhere else but my clinicals and I feel I don't know what to do anymore (p. 9).

Student #5: I have this baby that you know, the other one I don't have to worry about as much because he is in school and sort of have the same hours but then all of a sudden, I have got high babysitting costs and what I found was hard is that I couldn't put the baby in daycare and get subsidized because the baby is too little. I couldn't find an infant spot, so then I had to go private and the young teenager that I am paying, she doesn't give receipts so I just pay sort of under the table so it's quite costly for [me to pay] her. What I pay for my baby would be what I would pay for all of them if I was subsidized kind of (p. 16).

5.2.2.3.4 Ethnocentrism

Aboriginal nurses identified ethnocentric pedagogy and curriculum in their past educational experiences. These nurses recognized a slow transformation away from ethnocentric pedagogy and curriculum and identified the importance of providing all student nurses with information about the influence of colonialism and neo-colonialism on lives of Aboriginal peoples.

Aboriginal Nurse #1: I'm not here in isolation; I'm a product of history. I come from my great grandparents, grandparents, parents and myself and I carry that, the strengths and also the hurts and I deal with that and so I've taken that responsibility on myself as a person to stop some of the things right here that may be generational but also to work with the strength that I've been given through my family and I went to talk to [student nurses] and the whole class was on colonization and the effects of it. I said this is really good they're teaching this class in the general nursing population at [school of nursing], so excellent...I went back there and it felt very good for me to share my story. I know it's a story quite like other Aboriginal women in our country. And I know that a lot of this stuff is institutionalized. I know that. I know that we have to deal with it and I know that our communities and our families are hurting and I know that we all have a responsibility to work past that and to heal ourselves and to assist other people around us in healing. To me it's a broader issue than just a nursing program. It's something that infiltrates every institution in Canada and every organization....When I was talking about colonization and how it's infiltrated and its part of institutions, the...schools of nursing I guess are no different because it's all very much based on Eurocentric values, very much so – western medicine practices very much so. And so I grew up learning that. I wasn't aware at that time that I was learning that. It wasn't until later in my life when I started to learn about my culture and our history and our world views and to say I really like this and I'm proud of this and I'm proud of where I come from. It wasn't until later in my life that I started doing that because at that time there were no classes at the [postsecondary] level that taught that. You see when I went to university later and I took Native studies classes, I took women in history, Aboriginal people in health, I took anything that I could take that would teach me why things were the way they were because I've seen our people with any kind of diseases twice, three times as much as other people, alcoholism, abuse, all the things that were resulting from a history that was very hurtful so of course probably in the last 20 years in the universities as they've been teaching those things, maybe not even that long. That was where I learnt this stuff. I learned it because I wanted to find out the "whys" and so when I was in [the school of nursing] in [the 1970s] they didn't have those. But when I go back there now they do have something that is teaching the general population. Of course at that time it was very Eurocentric, western world views and values that were taught to everyone that went through

that program and that permeates our society that white is right. There are now courses where you can integrate your worldviews and your ways of dealing with wellness and sickness into how you work with people and that's a really good thing (p.4-5).

Current ANS perceived that the nursing curriculum was entirely comprised of information regarding Euro-Canadian culture, health beliefs, biomedicine and its related nursing knowledge and practice. Although health care needs are paramount in the Canada's Aboriginal population, information about the influence of colonization and neo-colonialism on Aboriginal health was not provided in the curriculum. Although all nursing students would provide care to an Aboriginal patient, family, or community at some point in their nursing education program, information about Aboriginal culture, health beliefs, and traditional healing methods was severely lacking. When Aboriginal health care issues were addressed, astounding statistics were listed that reflected negative aspects of Aboriginal lifestyles such as proportionally higher rates of child abuse and neglect, suicide, diabetes, renal failure and substance abuse. Positive aspects of Aboriginal peoples' health beliefs and culture were not addressed.

From the standpoint of ANS, ethnocentrism resonated from the nursing curriculum. Findings from the fieldwork indicated that nursing students (ANS and Non-Aboriginal) perceived that the curriculum was lacking pertinent information about Aboriginal culture, health beliefs, health issues, and traditional healing.

Field Note, 10/05/02 – I went to a fourth year nursing classroom this morning situated in a lecture theatre. There were approximately 80 students attending the class. The instructor announced that several students approached her about having a presentation about the Medicine Wheel. She asked for a show of hands as to how many students wanted a guest lecturer to present information about the Medicine Wheel. All of the students raised their hands. One Non-Aboriginal student voiced her concern that she was in fourth year about to graduate and go out into the workforce with no information on Aboriginal culture, health beliefs, health issues, or traditional healing. Many students nodded their heads in agreement.

Student #6: So we didn't really, nothing was mentioned about the Aboriginal population at all. So tomorrow I start my clinical at the [hospital] and we are on the ward and that has a lot of Aboriginal diabetic amputee patients (p. 12)... There is not enough Canadian information. It is more Americanized and I would really like to find good Canadian information... And I also think that there should be more Aboriginal information, health information especially... There is a different life on a reserve than there is for that same person to live in the city or anywhere else. And it's not only traditional values. It's food. For example, a thing of milk is atrociously expensive but a can of pop is fifty cents, so when you have welfare, you can only afford whatever, so I am sure that is one reason that they have a high diabetic rate... (p. 14)... I have yet to hear one of my instructors talk about the Aboriginal population in X and or Z and/or Canada... It is just strictly from the European book and I am not anti-white or anti-anything, but that is just the way it is and there is only one Aboriginal course, Native studies course... that is mandatory and I don't think that gives people a lot of, because it is just a general, it's Native peoples study on Canada (p. 24)... I think it would just be nice for everybody who came through the nursing program to at least experience it once, just because Canada has a big Native population (p. 25).

In rare instances, some instructors adopted a culturalist approach when traditional Aboriginal communication styles and behaviors were addressed. Some ANS appreciated that even tidbits of information about Aboriginal peoples' cultural beliefs and behaviors were offered. ANS identified how some instructors sought their input and how ANS shared information about the diversity within the Aboriginal culture and the dangers of relying upon cultural essentialism.

Student #19: They [instructors] keep talking about cultural stuff and then in our labs they keep like turning to me and asking me what Aboriginal people think of like touching or eye contact and I just tell it like it, if they have a question... What they are teaching in class and in the lab was Aboriginal people don't look you in the eye and stuff and I was like maybe traditional like real traditional people are like that. Like I know that my friend wouldn't look at my mom in the eye and that was her sign of respect, but she got offended so I use that as an excuse. Some people do and some people don't – not everybody. So what the heck? Quit saying that everybody won't look you in the eye (p. 15).

ANS also experienced ethnocentrism in nursing pedagogy in that they were required to alter their culturally appropriate behaviors and communication styles to avoid conflicts with teachers resulting in a failing or low grade. Conformity was mandatory. Assertiveness, verbal and non-verbal expressions of enthusiasm were expectations but

sometimes, the clarity of these expectations varied. In order to pass a clinical course, assertive behavior and Eurocentric ways of expressing enthusiasm were required. At times, ANS struggled to become more assertive with patients, other students, teachers, and nursing staff. If ANS continued to display passive behavior in a clinical course, they received a failing grade. In order to acquire certain marks in a theoretical course, enthusiasm required outward demonstrations in the form of readily speaking up in class and offering to be the first to participate in a demonstration or role-play. When ANS were unable to alter their outward expression of inward ideas and emotions, they experienced conflicts with their teachers and lower grades.

Student #24: In my culture, I can't look anybody in the eye and as I was talking to one of the instructors and she said, she pointed out to me, "You are not paying attention to me." And I said, "I am." And she goes, "Well, how come you are not looking at me?" she said. And that's why I say I want them to understand me as an Aboriginal. I don't want special attention. I want them to know where I am coming from, where I come from, too (p. 2)...I am not a confident person like where cause from where I was raised I am raised to be a passive person and to put people, that people are ahead of me all the time. And then what I found, the instructor when I was trying to, it seemed like when I was trying to be like that, they wanted me to be like [assertive] and I couldn't do that and then it seemed like that was a fault, that was a negative thing (p.10).

According to the ANS, the culture of nursing education was rarely identified and analyzed. The culture of nursing education was a taken-for-granted feature on the parts of faculty and administrators and students were required to conform to the cultural rules.

Student #11: I think it's a lot of the old school nursing that is still in here which is hard to get into too you know because you have the old attitudes – "Okay, you have to be like this, you have got to be like this, you have got to be like that." But it's not like that no more and there is so much more things that have come into play that they are not looking at, and it's just like, "Nope, nope, nope, it's like this"...They should evolve with society and they are not (p. 12).

Aboriginal Nurse #4:...but the first year that we did the clinical aspect of nursing, we had to, one of our classmates was immediately, suspended or terminated, because her English was poor and her attitude was, let's see what did they say, it's not enthusiastic I think it was enthusiasm was a sticking point, so that's what the written expectations that you were enthusiastic, but the subjective evaluation of somebody's enthusiasm can vary widely, Mary was very enthusiastic, she was

40 years old she was going into nursing and it takes a lot of enthusiasm to go into nursing at 40 years old. So, but she just wasn't enthusiastic enough apparently and that was purely subjective evaluation of her commitment to nursing... I remember one of the students, would walk on to the, she was very quiet, very smart, walk onto the ward and smile at everybody, touch some of the patients on rounds, but not say good morning, and not say how are you. She connected with everyone, and most of us, and that she was the most marked Native in that kind of behavioral greeting. There is no words spoken necessarily, there is a connection made, and most of the native nurses in some degree had that same kind of social nicety. It was not in your face hello, how are you, good morning, how did you sleep, you look at a person's eyes, you look at a person's body and they looked at you and you made a connection. You could tell how they slept, you could tell how they were this morning and it was not necessary for them to make the effort to verbalize...

Donna: Right.

Aboriginal Nurse #4: And most of us could make the crossover to a non-native person and offer that kind of greeting. Probably 6 or 8 of the Native nurses, didn't make the crossover because they were straight out of an isolated reserve and had not spent any time in a larger society and had a difficult time making that crossover and offering that kind of social nicety first thing in the morning.

Donna: Did the clinical teacher, or did the written expectations of the clinical course say that was an expectation?

Aboriginal Nurse #4: It wasn't a written expectation.

Donna: Okay.

Aboriginal Nurse #4: It was a, I guess the written expectation was that you made rounds and checked with all the patients. The interpretation of the instructor was, you walk in and say hello, how are you? That wasn't written, that's what the expectation of the instructor, the written portion says you make rounds and you check with all the patients when you first get on shift, right? The instructors, interpretation would be that you make rounds and you say hello to everybody and you ask everybody how they are. That's the instructor interpretation.

Donna: So with the native students who just use their typical ways of communicating and connecting when they were told by their instructor that their behavior was not up to the school standards, do you remember what the students' reactions were?

Aboriginal Nurse #4: Mary was devastated when she failed her clinical portion and as were a lot of us. Because they couldn't identify the difference between a Native moray and a larger society moray then they didn't know how to fix it. All they knew is that they were failing (p. 10-14)... You see the unfortunate thing is that not only the instructors come in with that kind of ignorance, a lot of the nursing students from the north come in with a greater ignorance of what kind of insolences they are going to face, what kind of pressures they are going to face to change who they are, to change how they act, to change how they talk, to change how they dress, to change how they do their hair, everything (p.18).

Reflecting on the cultural interpretations of enthusiasm and ways of communicating caring, this participant offered suggestions on how to ensure fairer evaluations of ANS' clinical performances and participation in classrooms.

Aboriginal Nurse #4: I think that if you have people who are able to interpret Native behavior and able to interpret Native styles and communication, in a position where they can do some good and have some power to veto an instructor's assessment of a student's behavior then that would make a big difference in allowing Native students, Native nursing students, or any students, to finish a course (p. 20).

A current ANS described a situation where an individual working in a student services department visited a clinical area for the purposes of supporting ANS and providing the clinical teacher with additional insights into the students' performance.

Student #23: I was in clinical and this was my last rotation, my last clinical experience. My instructor approached me and said that [an administrator] wants somebody from the access program to come with me to clinical. They had told me. She said that they told me that somebody is going to be with X and... So he did come and everything was perfect and everything was excellent... One of the things he said that I am not sure if this is right but he goes, "I want some, if students are having problems I want to see how I can help them." So he wants to observe (p. 28).

ANS described several situations in which they believed they were demonstrating respect towards patients and families. Their standpoint was that clinical teachers would reprimand them for their "passive" behavior and lacked an understanding for the ANS' way of showing respect. In the following vignette, the collision between Aboriginal culture and Non-Aboriginal nursing culture is illustrated. Here the ANS believed she was demonstrating respect for a patient and family as they received "bad news" from a physician. In this situation, a clinical teacher might analyze the ANS' presence in the room as disrespectful in that the patient and family's privacy was not honored.

Student #22: I had to write a progress note but because I was delayed in doing that, I had a really good reason for it and that was I got stuck in a room where they were talking in the bed next to me. They were talking to the patient's family. The doctor came in and said you know they were talking about a terminal illness with them and I am sorry but I am not going to walk out of that room when they

have just been told, you know your father looks like he is not going to make it. It's hopeless...I am not going to leave. I was stuck in that room for half an hour because of that. I just thought, "How can I get out of here?" when they are waiting for me. She [clinical teacher] is going to have a cow. How can I get out of here? I can't leave. I just sat there and I thought, "Oh well, if I get in trouble, then I get in trouble. If I make her wait, then I make her wait," and so I waited (p. 16).

By altering their communication styles to "looking people in the eye," being verbose and perky, ANS' newly revised behaviors contradicted their traditional Aboriginal values for respect and deference to Elders and teachers. ANS who had difficulty changing their communication styles due to value conflicts with their traditional cultural upbringing were asked to leave or chose to leave the program.

Student #6: I think my biggest problem is communication skills. One example was a patient wanted to lie in bed all day and that was perfectly fine with me. I was like oh that's okay, you don't have to get up if you don't want to and I got into trouble for that (p. 17)...So for me, I have to learn to communicate or be more assertive with patients (p. 18).

5.2.2.3.5 Racism

Visible and non-visible ANS observed and detected racism in individuals, groups, and processes within the schools, hospitals, and community placements. In the learning environment, several Non-Aboriginal peoples exhibited racist attitudes and behaviors that were hurtful. In most cases, unwitting insensitivity and/or lack of knowledge about the influences of colonialism and neo-colonialism were demonstrated as Non-Aboriginal peoples openly expressed viewpoints that Aboriginal peoples were all the same and had numerous resources available to them. I identified how greatly the historical context of Aboriginal education shaped ANS' current experiences. ANS who perceived that they were treated in a degrading and disrespectful manner by nurse educators described how these experiences "further added the fuel to the fire of how First Nations people were treated" (Aboriginal Nurse #2).

Field note. The student went over the consent and commented on the Residential School section. She said that her father went to Residential School and studies show that the effects trickle down to the children also.

According to Jackson, Smith and Hill (2003), there are two main forms of racism: passive and active. Passive forms of racism included being ignored, being invisible, or being singled out (Jackson, Smith, & Hill, 2003). ANS described their perceptions of passive forms of racism exhibited by some nurse educators, Non-Aboriginal student nurses, several nurses, and other health care professionals. ANS described experiences of being ignored and manipulated because of their Aboriginal ancestry and some nurse educators' lack of knowledge about the diversity within the Aboriginal culture.

Student #26: I have heard some complaints about they [other ANS] are being ignored or being, jostled around because of their race background I guess and like sort of being ignored, being pushed around into doing things that they weren't even supposed to be at, doing some things... You could have an instructor that talks very ignorantly... But yet that is just how they are (p. 25).

Several ANS perceived that their repeated requests were ignored for tutorials. Despite four visits to a student advisor, ANS' requests for a tutor were perceived to be unheard as ANS experienced no assistance in this matter. Passive signs of racism also occurred in clinical and community settings. ANS perceived that buddy nurses ignored them because of the visibility of their Aboriginal ancestry.

Student #14: I have had a bad experience because I have repeated my clinical. The first time I found hard. I don't know if it was the hospital or their way of working because all hospitals have different atmosphere.... I don't think there was very much support there between our buddy nurses. It was more or less you know go and do what you researched and do it and if you have any questions [ask] your buddy nurse. We didn't have a buddy nurse and I didn't have one (p. 11).

Due to her perception that buddy nurses were not supportive of her learning, the above ANS chose to withdraw from her first clinical course. Voicing a concern for lack of learning opportunities was not considered.

Another form of passive racism occurred when ANS were unwittingly singled out as being representative of all Aboriginal peoples. When ANS had darker colored skin and/or an Aboriginal accent, they were more visible to Non-Aboriginal peoples in the classroom, laboratory practice sessions, and in their clinical placements. The more visible ANS were, the more they were subjected to being singled out by Non-Aboriginal individuals and groups.

Student #2: I am visible in every way. Some people have forewarned me what some of them [nursing faculty] are like and they say keep fighting it, keep going. They encourage me to keep going (p. 1).

One ANS volunteered to participate after feeling frustrated and angry due to this incident when Non-Aboriginal nursing students singled her out.

Field Note, 05/05/02 - Received a phone call today from X. She volunteered to participate in the study. She told me that she just came from class and she was really mad. During the class, students were provided with a case study and had several questions to answer related to the case study about an Aboriginal man. The question was, "Why did Isaac die?" The students turned to the ANS and said, "You're Aboriginal. You must know the answer."

This ANS chose not to share her thoughts and feelings with the teacher and classmates about this incident.

Student #2: I've learned a long time ago not to let being Aboriginal get in the way of my learning to become a nurse. But sometimes they push me right to the edge and it takes a lot of willpower not to say anything...Another thing too in class, you're Aboriginal and if they want to do something Aboriginal, they try to get you to be in their team, in their corner...They used me. They used my personal experiences (p. 7).

Being singled out as a representative of all Aboriginal peoples caused many ANS to perceive that they were in a "fish bowl" and that they had to perform especially well.

Aboriginal Nurse #1: I remember having to try very hard. I remember really having to show people and I took that because I'm Aboriginal I have to be twice as good to be as good as anyone else. I remember that now. I worked very very hard (p. 18).

Several ANS voiced their anger and frustration about the negative portrayal of Aboriginal peoples in the curriculum. When identified, Aboriginal health issues were

described in a negative manner that lacked relevant contextual information about the influences of colonialism and neo-colonialism. ANS supported each other to persevere despite the odds against them.

Student #26: Whenever I hear about Aboriginal people, it's always like they are the highest number of people that have died, the highest number of cases of this and the highest population even, one of the highest populations, but yet there is nothing positive being said about it. And one of the Aboriginal students that I know I go to school with, she is very upset about it because she said, "I don't know. I don't know why I want to come here because it's so, it's always about the setting, you know how it is expressed about Aboriginal people... But then I told her, don't be so upset about it because it's a wakening call for you (p. 12).

A faculty member was perceived to lack an understanding of cultural beliefs and behaviors as she requested to see a newspaper clipping of an obituary as proof that an ANS missed several classes to attend a funeral service in her home community. The ANS perceived that the faculty member did not trust or believe her and did not understand the community's tradition of mourning the death of a community member.

Sometimes, ANS appreciated when Non-Aboriginal students and nurses asked for information about Aboriginal culture if the context, tone and words were perceived to be respectful. As such, the ANS were honored to share information.

Student #26: Some nurses did express that they don't know about the [Aboriginal] culture, ...and even some students have...I feel good that they are trying to find out. Like I feel privileged to tell them about it because why not? If it's going to help them in the future, sure why not?...There are students surrounding me already – What's a reservation? And they all turn their heads when I was talking about it. They wanted to know more about it (p. 9 -10).

ANS described their experiences of active forms of racism in their learning environment. These experiences consisted of hurtful verbal assaults from some Non-Aboriginal students, nursing faculty, nurses, and physicians that typically crept into informal conversations (Jackson, Smith, & Hill, 2003). The following metaphor described one ANS' perceptions of the power or racism:

Student #20: Ya I am very discouraged, very. There is a couple of times that I wanted to quit because a lot of these other Aboriginal students or other minorities have told me that they feel it [discrimination]. It's there they say. Just I am scared. It's kind of discouraging me. Not like. It's like I am the rabbit and some cougar is going to attack me and I'm going to die (p. 11).

Some ANS were told to anticipate racism by Aboriginal nurses with advice that ANS should voice their concerns about racism.

Student #29: And the public health nurses pushed me and you are going to encounter this [racism] and that but you know what just stay with it...Ya and they are really good though. They tell me straight out – like the racism, the change and everything and they said just talk. If you get in trouble just keep on talking because sometimes you just got to be heard (p. 25-26).

An ANS voiced her sadness when exposed to negative comments about Aboriginal peoples from classmates and medical professionals, but perceived that she was safe identifying herself as an Aboriginal person and responding to these negative comments by attempting to educate Non-Aboriginal classmates and health professionals.

Student #9: We had a web chat for our cultural anthropology and part of our thing was that we had to go on the Internet and put comments and bring some issues into focus and all that stuff and just tell like anything you could put on there. And in one of our classes I guess, one of the fellows, he was talking about Aboriginals, right? We always did, right? This fellow is like, "Ya and I drive around the [Aboriginal neighborhood] and I see kids barefoot and they are always little Aboriginal children." So I was like, "Oh, my God! This person does not even live in the [Aboriginal neighborhood] like whatever." So I just said, "You know I work in a professional environment and I hear comments from professionals that people are supposed to be looking out for – saying mean things about Aboriginal people and all that stuff," and without, being ignorant basically, and I said, "That could be one of my relatives running around barefoot in the [Aboriginal neighborhood]." ...But the thing about it is that I think the person took offence and then it was coming back to me and then I wrote something. I said, "I am not hating on anybody." I said, "I think that this is really good that we are bringing this into focus, you know and your comments and I said, "I am grateful for everybody's comments that they are making and all that stuff (p. 36-37).

However, the majority of ANS did not feel safe responding to nuances and comments from Non-Aboriginal classmates and health care professionals. Although several ANS

did not experience any racism, they were prepared to remain silent if it was encountered.

Student #16: Like even if I seen something I would be mad but I wouldn't really say anything (p. 25).

"Rocking the boat" was perceived to be dangerous. ANS who spoke against racism may be subjected to a backlash such as failure in the nursing program.

Student #31: I think you are looked down on. I think you are frowned upon. Like I didn't feel that with my clinical instructor... Being Aboriginal you'd certainly be frowned upon by people cause they think you don't know anything. That what I think honestly... You know you are looked down upon, frowned upon because of the color of your skin, like cause of who you are. Like you know it's tougher, like last year I didn't think it was so bad but this year, like just being in the clinical setting. I have only been there for 12 weeks and we are going to move already. I just think that there is, I see it already, and I try to not you know feel that way but sometimes you just, there is no way to get rid of those feelings... I feel it from my group. I can't say I feel it from my clinical instructor... I think I feel it from my group more (p. 12-13).

One ANS shared her experience of receiving verbal assaults from a staff nurse.

The ANS chose to inform the clinical teacher about the situation. In this rare instance, the ANS perceived that the clinical teacher was supportive but ineffectual on preventing further verbal attacks.

Student #2: There was an incident on my last rotation and there was one nurse who was very prejudiced against Aboriginals, so she didn't like me there... At every opportunity, she tried to make me look like a fool, she tried to screw my stuff up and then when she couldn't do it, because I'm very thorough and my instructor knew me to be honest... [The clinical instructor] talked to the manager about what was happening and she couldn't get anywhere but after a while I think she got reprimanded about that and then at every opportunity, when I was alone she would talk down on me. One time when I was doing my nursing notes, I was by myself and there was this nurse and nobody else was there, but she told me to fuck off... I was charting and she wanted to sit there and have her lunch and she told me to fuck off. I let my instructor know though and we had a talk (p. 11-12).

5.2.2.3.6 Conflicts with teachers

Guided by the theoretical and methodological perspectives and my positionality as a former nurse educator, I acknowledged that an inherent power relation existed

between nursing faculty and students from all cultures. Highly influenced by the history of Aboriginal education in Canada, this power relation was further heightened when the student was visibly of Aboriginal descent. Many of the situations depicting the power relations between faculty and ANS were related to clinical teachers' evaluations of ANS' clinical performance. I present ANS' standpoint and interpretation of the clinical teacher's evaluations that reflected the ANS' perceptions and feelings within these intergroup relations. Please note that no fieldwork occurred in the clinical areas³³.

Student #20: I felt she [clinical teacher] was always on me and she and I felt that she exaggerated a lot and she put me on clinical probation for something that I felt that was not fair at all...Then that's when she kept saying I think you are better off with the health care aid program. And I felt like, I felt like she slapped me on the face...Three times she said that. Three times she put me on clinical probation and then it was like she just was trying to find mistakes and I thought the clinical probation was not called for...I am not the type of person to be fighting and arguing with anybody that I don't know. And it's not comfortable for me and I was raised that way. My father used to tell me, "Don't talk back." That's how he taught me and I, that's why I didn't appeal (p.8-9).

Student #24: Then I had one more day before the last day of my clinical...She [the clinical teacher] pulled me into the linen closet and she goes, "Okay tomorrow is our last day and I have to tell you 99.9% I am not going to pass you and I said. I just started crying and then she goes, "I feel that you are not ready for Year 4 and I am going to tell you right now that 99.9% I am not going to pass." And you still want me to come? "I still want you to come." And then I said and then she goes, "You know what I can find some things that you cannot do and fail you but I am not that mean. No, no, I am not that mean." And then she goes, "That's just the way the cookie crumbles."...As soon as we got to clinical, she made me do everything, like dressing changes. She made me do more than I did the whole rotation. She made me do everything like and I don't know what the point was, why she made me do so many...I said to her, "How come you didn't tell in the middle of our clinicals?" And she goes, "Well, I just started to notice you around this time" (p. 10-11).

In many instances, ANS did not fully grasp the reason why nursing instructors evaluated their theoretical or clinical work with a poor or failing grade. The low grade

³³ As no fieldwork was conducted in clinical or community sites, I was required to rely upon the participants' accounts about social relations in these settings. In Chapter Six, I describe the social relations in clinical courses from the standpoint of nursing faculty members. With ten years experience as a clinical instructor, I was able to read ANS' and Aboriginal nurses' accounts and perceptions of social relations and reflect upon my past experiences as a student and teacher to identify the inherent power differentials in the student-teacher relationship.

was perceived as a punishment for something that was lacking or wrong; however, ANS could not provide an exact reason for the appraisal of a substandard or unsatisfactory performance. ANS were unclear if they lacked the necessary knowledge base, written communication skills, verbal communication skills, or competence in nursing practice. While the explanatory model might have been clear to clinical teachers, the message was not understood by ANS. In these situations, I identified a clash occurring between the culture of nursing and the Aboriginal culture. ANS were confused regarding what they were required to prove in order to pass the course.

Field Note, 05/05/02 – Aboriginal Nurse #5 explained that she had failed a theoretical nursing course and had to repeat it. When I asked her to explain the reasons why the instructor had evaluated her knowledge as unsatisfactory, she said, "I don't know. To this day, I don't know what I did wrong." This nurse was sad and angry because the failing grade affected her future. The F affected her GPA, which she said would negatively influence future applications to postsecondary institutions.

Student #14: Well, actually I am repeating a course for the third time, this term. The first time I took my course, I failed and I didn't know why (p. 8).

Aboriginal Nurse #1: I thought that I was doing okay and I never failed any exams or any, uh, and as far as I was concerned I was doing okay then, I wasn't according to one instructor, she failed me in the clinical, said I wasn't doing as I thought I was. So anyways, she failed me and one of the other instructors said, no amount of talking would make her change her mind, she was quite adamant that I wasn't performing, so as I said I didn't fail any exams and I had excelled in my bedside nursing, and when I took the [nurse] role, as far as I knew I was going good. So anyways, so I dropped out and it really left me wondering, well I still want to become a nurse, that's been my goal...

Donna: What is your recollection of the reasons behind the failure?

Aboriginal Nurse #1: Oh, she said I was not performing up to my, to par, that was just about it, that I was not performing as I should... She just said that I was not performing and one of the other instructors said to me, I'll try to talk to talk to her too. They knew what I was doing, they knew me and knew that I was doing okay. (p. 1-2)... For a while I felt like, well I guess, I am not good enough to go into nursing, maybe there is something else. For a while I thought that (p. 4).

5.2.2.3.7 Inadequate funding

ANS identified that the most challenging factor of being an ANS was inadequate funding. Band sponsorship, Canada Student Loan programs, and other forms of

financial assistance to Aboriginal peoples were controlled ultimately by the Canadian and provincial governments. In the case of Band sponsorships, the political structure of the Band council influenced how education funding was allocated. From the standpoint of ANS, inadequate funding had the most powerful impact upon their lives. In hopes of escaping future poverty, ANS were forced to endure financial struggles during their tenure in the school of nursing. Constant worry about finances negatively affected ANS' ability to concentrate on learning how to become a nurse.

All participants identifying themselves as First Nations successfully acquired Band sponsorship. However, Band sponsorship was described as being similar to amounts that welfare recipients received. While most participants explained that they participated in this study to help future ANS, several readily identified that they were in dire need of the thirty dollar honorarium.

Field Note 04/10/04 – I was sitting in the waiting area of the access program. Aboriginal students were walking in and chatting to the receptionist. I noticed a file folder hanging from the receptionist's desk, labeled, "Food Bank Applications." According to the notice, if students wanted to acquire food from the food bank on Friday, they had to apply on Tuesday. I noticed three sheets of paper in the folder, assuming that three students predicted that they'd need food for their families by Friday.

Student #24: [Band funded] The top thing that I had a hard time with was financial assistance...Like when I was doing this – my studies was blocked because my finances like oh how am I going to meet this bill and how am I going to meet that bill and never mind trying to study, you are too worried about finances (p. 2).

Student #29: [no dependents, Band funded] In order to be funded, regardless of what you are taking, you are taking 6 credit hour courses whatever, you have to take 3 courses a term. You have to pass with a GPA of 2.5. You get any allowance. You are already a student. You can't even afford to buy yourself groceries. You buy what you can. Plus for nursing, you got to dress up. I mean – look at the way I am dressed! And I got to go in the community like this and things like that...And I only get \$575 a month – that's \$575 – that's not including my hydro I got to pay, so by the time I have to like my bus pass...but it's going to be hard (p. 14).

Eight participants identified themselves as Métis peoples. They acquired Canada Student Loans or other forms of financial assistance such as access bursaries and scholarships or they personally funded their education. These participants expressed frustration with the rules, regulations, and application processes for Canada Student Loans. Métis organizations only provided financial support to Métis students in the last fifteen months of a postsecondary program, which inadvertently advocated shorter programs and subordinate roles in health care such as the health care aide programs. Because of these stipulations, Métis students did not find Métis organizations helpful or supportive in funding nursing education.

Student #12: I applied for funding [from a Métis organization] for school and they wouldn't pay for a nursing course because it was too long in duration... So they told me no, we can't do it because it's more than two years. Pick something different (p. 2).

Student #15: I took out a student loan and that's really frustrating me because it is very hard for me to get funding, to get my student loan. Last year, I wasn't accepted for a student loan so I have to borrow some money from my brother but this year I got just enough. But I don't know it's just Canada Student Loan, the questions that they ask you. I just find that it is really, like I don't think that they take into consideration that you have a family... I just feel frustrated with the whole process with student loans (p. 4).

In many instances, ANS acquired part-time employment to compensate for inadequate funding from Band sponsorship or Canada Student Loan programs. Part-time employment further removed ANS from their families and nursing studies.

Student #23: [Band funded] I have to work part-time... It's very busy. You were trying to get hold of me those times and I am never around (p. 7)... I used to clean houses on the weekend but that didn't pay nothing. So I figured I need to do something better. So I became a dietary aid in the meantime (p. 8).

Student #26: [2 children, Band funded] I not only work part-time. I have two part-time jobs (p. 5).

Several First Nations students identified sponsorship rules that required careful reconsideration. Inconsistencies and perceived nepotism at the Band level were addressed. ANS suggested that Bands conduct an assessment to clearly identify the

discrepancy between financial support and financial need. ANS recommended that Band Chiefs and Councils lobby the government for an increase in financial support of Aboriginal peoples pursuing postsecondary education.

Student #6: I am low on the totem pole and that is fine with me but there is other people who have gone to school three different times and have got funding. So I am not really sure how the Band thing works – how they pick and choose funding...and that happens on my reserve (p. 8).

Student #31: For the past three years, my cheques have been anywhere from 10 to 15 days late in payment...They have been put in the mail and people have transported them to [city] and just haven't dropped them off for whatever reasons and my bills have always been late like for the past three years because the money has always come in late. It's never been on time. And during the holidays and stuff like that it's even worse because the cheques are even delayed more...So I always had trouble getting my cheque...If my bank knew that I wasn't working because I didn't tell them that I was going to school, they would have taken my overdraft away and thank God for overdrafts because that's what gets you by (p. 8)...I think there is a lot of nepotism in with the Bands and that and if you are not related to whoever is, whatever you just don't get funded and like plain and simple (p.10-11).

Student #11: I think what needs to be done is for them [the Bands] to come in and actually look at the financial situations that we live in. Like I don't think that they look at every year rent goes up. I don't think they actually really look at the daycare funding that we have to pay for, and this year there is like there is numerous other monies that need to be paid for, for like copying and for like – it's just everything is going up and they are not going with it. They are just remaining the same. They don't look at what needs to be done (p. 6).

Some ANS suggested that the course load requirement be more flexible for Band sponsorship. Pro-rated funding would be beneficial to some ANS, facilitating their choice of a course load that was most suitable for their lifestyle and learning.

Student #14: Because I have to have a 60% course load to be full time for sponsorship (p. 2)...So I think that the last three terms it wasn't how I was studying. I think it was the course load we had because we were taking [medical nursing] theory and we were taking [medical nursing] clinical because we were taking our third year lab skills, so it was like every day constantly switching from one thing to another (p.9).

ANS identified that inadequate funding negatively affected their abilities to purchase necessary physical resources such as clinical uniforms and a home computer with access to the Internet. Fortunately, computers and Internet access were available to them on campus. However, traveling to the campus to work on a computer was costly in that ANS were away from their families. At these times, ANS were required to hire a babysitter to care for their children.

Student #7: For a program that's very complex, the homework is 98% computer related, a lot of, because we don't have lots of money, we can't afford a computer. So that would help to a degree, big time because I am here a lot of the time having to stay late and work on the computer... Because I need a computer at home because I want to be with my kids a lot of the time (p. 5).

ANS were reticent to share with others that they received Band sponsorships. ANS perceived that Non-Aboriginal students and faculty were resentful and believed that ANS were receiving "handouts" and experiencing a "free ride."

Field Note 12/10/04 – She ended with the story of a classroom teacher reading out the [recruitment notice for this] Aboriginal study. She said a non-Native student commented loud enough for her to hear, "More money for Aboriginal students." She told her that there are lots of studies that she could participate in if she looked for them.

Student #5: Another thing I don't like to tell anybody that I am sponsored because when you do that's when you get that, "Well your books are paid for. It doesn't matter." I get that all the time and still get it and I feel bad because they are complaining about their student loans and having to buy all these books and trying to, and another thing is that they want to photocopy your books because they know that well, you get them free so what does it matter?...The courses, they all give out the syllabus and it's like \$20 or whatever and it's just a photocopy pages that you got to buy it, so then I found that they would come and say, "Can I photocopy your syllabus because you didn't pay for it." You know that kind of thing, so I try not to tell a lot of people that I am funded...because then they are like, "You are not going to have a \$20000 student loan, aren't you lucky!" (p. 33) ...And that's what they think, they think that we've got lots of money and everything is paid for so what are you worried about?

5.2.2.4 Journey's end

ANS would exit the school of nursing several ways: (1) graduation, (2) temporary exit, (3) permanent exit by withdrawing or failing, and (4) transferring to another field. Student nurses were required to permanently exit if they voluntarily withdrew from the same course twice or if they failed the same course twice. Two participants were planning on exiting the program as soon as a seat became available in an educational program of their preferred choice.

Aboriginal nurses' stories revealed a strong sense of achievement by successfully completing a nursing program despite the odds against them. These successful graduates fulfilled their dreams of making a better future for their children. Successful graduates identified that they continued their lifelong learning in such areas as personal growth and acquiring needed information about Aboriginal culture and the influences of colonization and neo-colonialism on Aboriginal health.

Aboriginal Nurse #3: I know, what they give us [social assistance], I never drove, I never had a car, so I'm telling you like I said to myself, I am going to be a nurse if it kills me. That's the drive I had and I remember I am going to get off of this welfare business and I am not going to be on welfare because I hate it. It is degrading. I am going to be a nurse. And I am going to do it if it kills me and I did. I was really happy after I graduated and I got a job and I was making money and I was off social assistance completely and supporting my family (p.7)... It was great that I was able to do that work [employed as a nurse] and my children were still going to school and they both got their educations and it is wonderful. My children have a postsecondary education and good employment, which I am happy for that they got their education. I am glad that they didn't have to be educated on a reserve (p.8).

Aboriginal nurses described how they received several awards for their excellent nursing practice, which further affirmed that they were indeed "good" nurses in contrast to past hurtful failing grades in theoretical and clinical courses. Following successful completion of a nursing education program, this participant was provided with an opportunity to share her achievements and describe her experience of receiving an F

directly with the clinical teacher who had provided the failing evaluation. In this excerpt, the perseverance of ANS is also illustrated.

Aboriginal Nurse #2: Well, that's what came out of it, when she came to apologize to me. And well that is what I came across the same instructor years later, and of course she made a huge distort, she did, I was a guest speaker at a [conference]. I was a guest speaker there and when I was interviewed she was the same nurse must have heard my name or a bit of quiet - there were lots of people, and she said, "I think we know one another." I said, "Yes I know who you are." And she said, "I was going to go talk to you about what happened," and she said, "When I got hired on as the instructor there, the one place that I did not to go was surgery and I told them and that is all I can say was the reason for my attitude," she said. Why, because I was put in a place where I did not want to be? I said, "Don't make me an excuse to your personal specifics," I said to her, "If I had listened to you, if I had thought to myself that I am not going to make a good nurse, I wouldn't be where I am today. You almost ruined my life, but I kept on pursuing on what I wanted." And she apologized and she said there is one thing that I have learned from that experience with you is to be more helpful to people to seem to need extra help. Well that is a good thing that came out of it then, I guess it is okay that it happened, I said to her. But she did apologize and she excused that she did not want to be in surgery but that's where they put her. But she was not, that wasn't what she wanted in the first place. I said to her, don't give me excuses, you know, I am just so glad that I didn't listen to her. Because if I had where would I be today? (p. 5).

Several ANS identified that they temporarily exited their nursing program due to personal and/or academic reasons. Once the issue was settled or resolved, ANS were ready to tackle the journey again.

Student #24: I guess I have to take care of my kids, I have to take care of myself and I want to be a role model for my family and for people in my community because there is hardly any role models.

Ardelle: Right.

Student #24: So that's what keeps me going and I have to take a year off this year.

Ardelle: Right.

Student #24: And I still have motivation to keep going (p. 13)...

Ardelle: Did you decide to take a year off or did they tell you?

Student #24: No they told me because I needed a 2.5 [GPA] to continue and I have a 2.4...

Ardelle: What are you going to do?

Student #24: I will probably work.

Ardelle: What are you going to do work wise?

Student #24: I work in the community (p. 32).

Alternatively, several participants described the difficulties they encountered and their decision to end the pursuit of their dream. Although their dreams were shattered, they voiced a sense of relief by deleting the stress of student life from their lives.

Field Note, 05/10/04 – When I called to rebook an appointment, she informed me that she quit the program. I told her that I would be interested in hearing about her experiences. She was an identifiable Aboriginal woman with shoulder length brown hair. She seemed very tense and unhappy. She spoke about being so stressed out before clinical days and not sleeping until 2:00 A.M. and getting up at 5:00 A.M. to research more. She had a few bad experiences at this school. She commented that she was depressed while in school. She has a family with kids. Between family, work and school, she said that she decided to get rid of the one causing the most stress: school. She said that she felt a load of weight leave her shoulders when she made the call on Friday morning at 5:00 A.M. to the ward and her teacher's answering machine. She was repeating this particular clinical course as she had withdrawn from it before. She said that you are not allowed to withdraw from a course twice or you are out of the program... She said that she is going to work in a First Nations community and who needs all the stress and it pays well.

Student #22: Well it [the pace in the clinical area] goes so fast and it just, which is why I dropped, why I am withdrawing from [surgical nursing] a second time which is - apparently can't happen, so I guess I will be kicked out of the program. Just I felt like I am swimming in [surgical nursing] right now, well except for the fact that I just said that I withdrew three days ago. Now I feel free... My brain does not hurt anymore (p. 12).

5.3 Chapter summary

Starting from the ANS' experiences, I analyzed transcripts of interviews with 31 ANS and five Aboriginal nurses and related descriptive and reflective field notes to identify the standpoints of ANS. Stories from the 36 participants revealed a long and arduous journey to and through a school of nursing.

The journey usually began with a child's dream to become a nurse fuelled by a strong motivation to create a better life and contribute meaningfully to Aboriginal communities. Most times, alternate pathways such as having a family and/or embarking on different or related career paths diverted these Aboriginal peoples from the directly pursuing their dream. The journey to the school of nursing was hampered by the

actuality that Aboriginal communities were provided with substandard primary and secondary education. To enter into a school of nursing, ANS capitalized on available opportunities such transition or access programs.

The initial introduction to postsecondary education was complicated by culture shock for all ANS from northern communities in that they were additionally challenged to adapt to an urban centre and relatively large campuses where Aboriginal peoples were the minority. The journey through the schools was enhanced when ANS accessed and used informal and formal supports. By far, the most important resource was ANS' personal agency. Assertiveness, ingenuity and relentlessness were used to traverse through the nursing program despite many odds against ANS. Many ANS identified how they benefited by having the informal support of other ANS as no formal mentorship programs were available. Access students also acquired needed informal support through access personnel. Access programs provided ANS with many important resources such as counseling services, free tutorials, and information about funding sources. Access personnel provided ANS with a human element in an otherwise impersonal environment.

The intersectionality of gender, race, culture, economic status and geographical distance from supports magnified the stress level ANS' experienced. In instances where ANS held multiple roles: partners, mothers, students, daughters, and income providers – the stressors were extremely monumental. I used the term, intersectionality, to describe how these aspects collided to create double, triple, and quadruple jeopardy. I categorized these issues associated with intersectionality: personal issues, lack of social support, lack of available childcare, ethnocentrism, racism, conflicts with teachers and finally, the major obstacle – inadequate funding. These issues were shaped by the historical and sociopolitical context. Lacking

available and affordable childcare, ANS were often poised with difficult choices related to juggling their studies with safe and prudent care for their families.

By far, the most difficult aspect of being an ANS was inadequate funding through Band sponsorship or Canada Student Loan programs. Inadequate funding created the greatest stress in that these ANS were struggling to ensure basic needs were available to them and their families. Many ANS relied upon food banks to provide minimal quality nourishment to their families.

Intergroup relationships between ANS and Non-Aboriginal teachers were complicated by the historical influences of Aboriginal education. When ANS had experienced a failing grade in a course, they lacked clarity as to the specific reason why they acquired an evaluation that deemed their knowledge and/or skills unsatisfactory. On top of dealing with the power differentials of student nurse and teacher, ANS were required to assess and maneuver themselves in learning environments where passive and active forms of racism were exhibited and ethnocentrism was rampant. Most ANS chose to ignore racism. Rarely, an ANS would choose to point out negative stereotypes or sweeping generalizations and inform classmates, teachers, and health care providers about the influences of colonialism and neo-colonialism on lives of Aboriginal peoples.

The journey through the school of nursing would end in one of several ways: (1) graduation, (2) temporary exit, (3) permanent exit, or (4) transferring to another program of study. Aboriginal nurses described their sense of achievement and pride despite the many odds against them. These women described fulfilling their dream of becoming a nurse, providing a better life for their families, and contributing to the promotion of health for Aboriginal peoples.

6 TEACHING ABORIGINAL NURSING STUDENTS: THE STANDPOINT OF NURSING FACULTY

You are very brave to be doing this. You know I never would have thought of it being a brave thing before you know because I was just very naïve and a lot of what I believe I just thought that everybody believed (Faculty #18, p. 29).

6.1 Introduction

In this chapter, I further present the empirical findings of the research from the standpoint of nursing faculty. This chapter focuses on the experiences of 24 nursing faculty members from selected schools of nursing.

I analyzed transcripts from interviews with faculty members who volunteered to participate along with reflexive and descriptive field notes of my field work in classrooms and laboratory practice sessions to explicate perceived tensions between ANS and other social groups within the schools of nursing (the translocal). When I present perceptions of student-teacher relationships, I aim to describe social processes that have generalizing effects for ANS and faculty.

The theoretical and methodological perspectives guiding the study provided a template for my presentation of the findings related to faculty's experiences teaching ANS. Relying on D. Smith's social organization of knowledge (1987), I present how the text based rules and regulations within and beyond the schools organized the ANS' and teachers' experiences.

To protect the identity of the male faculty member, I altered his comments to reflect the standpoint of a woman³³. Identifiable features of certain stories were slightly

³³ Again, my committee and I acknowledged that gender shaped experience. However, it was more important to protect the identity of this participant.

altered to further protect the identities of participating ANS, faculty, and schools of nursing.

I organized this chapter to reflect the standpoint of faculty. In particular, I present faculty's perceptions of local, translocal, and extra local contexts that shaped their experiences with ANS. The local represents nursing faculty's embodied knowledge such as: their experiences teaching nursing, experiences teaching ANS, and perceptions of ANS.

The translocal context emulates the faculty's perceptions of their interactions with ANS. I present how nursing faculty perceived the schools' internal influences on ANS' experiences. Internal influences included student-teacher relationships with ANS, pedagogy³⁴ (including philosophies of teaching and learning), curriculum (including the portrayal of Aboriginal peoples), class sizes, and the schools' policies and procedures.

The extra local context also shaped the faculty's experiences with ANS. Outside influences were identified as the nursing shortage with an impetus to teach and graduate a higher number of students with a minimal increase in faculty positions. The nursing profession's standards of practice also shaped how nursing faculty were required to focus on outcomes rather than process-oriented teaching. Nursing faculty expressed a deep responsibility to graduate knowledgeable and competent generalist nurses. Finally, Band sponsorship and expectations from Aboriginal communities were noted to influence ANS' experiences.

³⁴ I use the term, pedagogy, to refer to the art and/or science of teaching with a particular focus on teaching strategies utilized by nursing faculty.

6.2 Local context

Guided by the tenets of the theoretical and methodological perspectives guiding the study, I analyzed the transcripts and field notes to decipher nursing faculty members' experiences teaching ANS. Nursing faculty's viewpoints will be divided into several sections: (1) profile of participating faculty, (2) limited experience teaching ANS, (3) perceptions of ANS and (4) perceived inequalities.

In the following section, I briefly provide a description of the participating faculty members. I proceed to describe faculty members' experience teaching ANS and their perceptions of ANS.

6.2.1 Profile of participating faculty

Twenty-four nursing faculty members volunteered to participate in a one-hour audio-taped interview about their experience teaching ANS. Of these participants, one was male. Most teachers were middle-aged, Euro-Canadian women with experience in nursing education. Although I specifically recruited clinical teachers and student advisors, only four participants identified themselves as clinical teachers, while two participants were student advisors. Several participants were administrators in the schools of nursing. The majority of participants taught theoretical classes and/or laboratory practice sessions. One faculty member placed an addendum to the informed consent form, stipulating that in my field work, I was provided with permission to attend only one of her lectures because she did not want my presence to disrupt classroom dynamics. To protect the identity of nursing faculty members, I refer to them as Faculty #1, #2, #3 etc. Of the 24 participating faculty members, only three teachers were novice nurse educators and 18 faculty members had over five years experience in a school of

nursing. Nineteen faculty members were from research site #1, while five teachers worked at research site #2.

6.2.2 Limited experience teaching Aboriginal students

In this sample, most faculty members were well experienced in nursing education. Limited information was provided to nursing faculty members about teaching strategies. These instructors learned how to teach by mimicking how they were taught.

Faculty #11: Another problem about nursing is that we always struggle with what needs to be in that curriculum and it's always this major battle about, "Well, I learned it this way and I think that's the way we all ought to learn it." And so that medical/surgical nursing is the most prominent thing and if it's not there we're in deep trouble. So we get stuck on all kinds of levels here and everywhere in terms of understanding what people need to know. Many of us are diploma grads and I'm very proud of that but I think it does shape your thinking in terms of how you also think you want to teach nursing (p. 20).

Although most teachers had greater than five years experience in nursing education, many participants acknowledged that they had limited experience in teaching ANS. Nursing faculty described their perceptions of the diversity within the student body and the impetus of seeing more ANS in their classes. However, they voiced a concern that they had not acquired proper guidance or preparation to ensure that they were able to provide cultural sensitive pedagogy and curriculum to ANS.

Faculty #12: I am impressed though, compared to [another province] the diversity in the classroom is greater... It's very diverse (p. 20).

Faculty #4: I have been teaching since 1989 – 13 years. No experience with Aboriginals. Possibly sometime in another school of nursing I may have had someone who was [assimilated] to urban ways but that doesn't stand out for me as anything significant... So I had no preparation in Aboriginal ways. I knew a little bit because of some course work that I had done and some papers that I had written and what not about breastfeeding in the Aboriginal culture. So I knew a little bit. And I have cared for the odd Aboriginal patient and family over my years as a staff nurse but very little exposure (p.1)... So I would say that I would really want to have had more preparation in appreciating the cultural differences and different learning styles and all that kind of thing which I did not have (p. 2).

Faculty #5: [Experience teaching ANS] – Well, it's limited. The experiences that I can think about most recently have been in my course for registered nurse students and when I think about it I actually had 2 students 2 years ago and I had 2 students this past year (p.1)...I've not done a lot of reading, haven't had a lot of experience with them and each student is different in the class, whether they're First Nations, whether they're Caucasian from [a city] or [a rural town] or whether they've immigrated from another country and so I try to be sensitive to that kind of thing (p. 11)...I think the classes in the nursing program reflect the culture diversity of nursing in the province and so I've always had students from other cultures in my class. There's always one or two Filipino nurses. There's often an Oriental nurse, not as frequently an Aboriginal nurse, although I have seen more of them in the last couple of years obviously. There's Métis, Mennonites, the whole range...I think sometimes we kind of get on a bandwagon about First Nations and I think there are other cultural groups in this province that we need to pay attention to as well but I understand the need to do that with First Nations because first of all there's funding and they do form an important part of our province. So I think it's important to address the issues (p.15).

Donna: Can you tell me how you were introduced to teaching ANS?

Faculty #17: There wasn't any introduction. It was...I just happened to look up one day. I know that I had ANS all along. It has never been an identifiable group. I have always had Métis students. The only reason I knew they were Métis is because they were funded by the [Métis organization] and then they will come up to you every class and you have to sign that yes they did attend the class. It's for funding reasons. And I said, "Oh, okay, fine. It's not a big deal." And I think that their experiences are probably different from the ANS who come down from up north... So it took me a few weeks to actually realize that this was an identifiable group with particular challenges. So there was no introduction around it. I kind of sorted it out myself through speaking to the students and eventually figuring out who a [person] at Access was (p. 1-2).

Several teachers acknowledged constraints that may have prevented their abilities to connect with ANS. These faculty members used reflexivity to identify that positionality and culture may create a barrier that prevented them from really knowing the context of ANS' lives. By reflecting on their privileged lives, these faculty members were beginning to acknowledge the influences of colonialism and neo-colonialism on Aboriginal peoples. These faculty members were "in tune" with the intersectionality of

gender, race, culture, and economic status and how this collision created multiple jeopardy for ANS.

Faculty #1: A constraint would be, I think, I'd be more able to address what it must feel like to live and work in the North if I had more of that time myself. I think another constraint is that I'm of a background culturally where I probably don't have barriers that a lot of people may feel if they're more culturally diverse (p. 9).

Faculty #11: You don't have to work here very long to see that we all look the same and now lots of us are a similar age. We probably grew up in reasonably similar circumstances and we're a pretty privileged lot (p. 18).

One novice educator acknowledged that she was "culturally clueless" and identified that the increase in student enrollment and thus classroom size additionally prevented her from attending to culturally diverse students.

Faculty #7: I can't really say [if ANS are in the class] because that person is just a number to me. Like I say, I'm not sure. One week I heard a student say something about being Native and that's how I noticed – that kind of thing. To look at her, I wouldn't even know.

Donna: So, she's pretty fair skinned?

Faculty #7: I guess so or she just looks possibly Asian or possibly Filipino. I'm culturally clueless (p. 19).

Rarely, faculty identified that they were experienced teaching many ANS over the years. These faculty members felt confident that teaching strategies were beginning to be more inclusive and culturally sensitive. Because of extralocal influences of a growing Aboriginal population, faculty members were becoming more open to aspects within Aboriginal epistemology.

Faculty #21: We are getting so used to working with Native students that it's not an oddity, you know, it's part and parcel (p. 5)...What I have seen over the years with having Aboriginal students in – that slowly Aboriginal ways are starting to be absorbed by the faculty, they are starting to understand it. It flushes out as a faculty and as a student body to be able to see that because certainly within [this city], a huge majority of patients in the tertiary care centers are Aboriginal and so that can't help but be good (p. 21).

Prior to teaching ANS, several teachers took the initiative to learn more about Aboriginal epistemology and health beliefs. One participant talked with ANS to learn more about their experiences as nursing students, while other members of the nursing faculty approached Elders in various Aboriginal communities for guidance in their upcoming teaching/learning experiences with ANS.

Faculty #18: ...so there is all kinds of other stuff I can tell you that I found out from my [research] but not all Aboriginal students see things in a circle. Some of them are linear thinkers, you know just so and I guess just the nature of the instructors some of them just you know. Everybody has different learning styles and teaching styles (p. 12).

Faculty #9: I tried to do a lot of research before I taught ANS for a number of reasons...I have a personal belief that it is imperative for First Nations People to have this and so I went to the Elder [at the postsecondary institution] and talked to her about what I need to do to enter this (p.12).

Rarely, nursing faculty members were provided with cultural awareness workshops or courses or courses on how to teach culturally diverse students. Although several faculty members found these courses worthwhile in offering a broader scope and further understanding of the Aboriginal culture, one teacher did not find these courses helpful.

Faculty #18: One thing that I think became very obvious to the faculty after a number of cultural awareness type workshops was when somebody [an ANS] calls, when an Aboriginal student calls somebody auntie, that doesn't necessarily mean that they are a blood relative. And but that doesn't necessarily mean that person is any less important than the blood relative, so if an auntie has died and they have to go to a funeral that we have to make those kinds of concessions for students and you know these people are very important in our students' lives and if they are important enough for the student to want to be there with them and support the family of the aunt then that is important that they are allowed to do that because they will feel better when they come back (p. 19).

Faculty #17: I have been to a few workshops regarding how to deal with minority students and frankly, they weren't that useful. It was essentially just be everything to every people, so what I do is just use a wide variety of teaching methods and hoping that I will hit something along the way (p. 18).

Cultural awareness and cultural diversity courses for teachers received mixed reviews. In the next section, I proceed to present how nursing faculty perceived ANS.

6.2.3 Perceptions of Aboriginal students

Nursing faculty members adopted various perceptions of ANS from their experiences. Firstly, I identified that most teachers were overwhelmed about the complexity of ANS' personal lives. Despite their lack of preparation to engage in the teaching-learning process with ANS, many faculty members demonstrated a high level of empathy and compassion as they attempted to connect with ANS.

6.2.3.1 Complex personal lives

Nursing faculty members were dismayed by the complexity and tragedy that ANS were enduring in their home lives. Nursing faculty would listen to ANS' stories and grapple with competing roles: teacher versus counselor. Teachers frequently referred ANS to personal counselors in student resource centers.

Faculty #3: They [ANS] seemed to have a lot of family problems and again being quite generic on that and perhaps unfair, they do bring their family problems to the theoretical class as well as the clinical. Either they're not there on time or they're having trouble transferring the knowledge because they're focused on what's been happening at home or back where they have come from (p. 2)...We encourage them, we have that thing here, the Access and we encourage them to go there, not necessarily for academic guidance but for more of support and maybe they can direct them to counseling services or an Aboriginal counselor of some sort. As a [faculty member] you can only spend so much time with them and as a [faculty member], I don't feel I should be the one doing the counseling. I'm not a psychologist or psychiatrist in any way, shape, or form, so I try hard to direct them to an area where I feel that they might be able to receive some counseling services...It's very difficult. It's very time-consuming and it's very...your heart just goes out to these people. Again, it doesn't matter who they are (p.9).

During student-teacher interactions, several ANS shared personal concerns with their teachers causing nursing faculty members to perceive that ANS were similarly

overwhelmed with the issues. Several teachers acknowledged that it was important to continue to support ANS within the context of their complicated lives.

Faculty #11: But I also don't think we ought to write people off because their lives are complicated. Otherwise, many of us wouldn't be nurses, many of us might be written off a long time ago. And so I think it is really about trying to understand that we all move through the world a little bit differently but lots of people have wonderful gifts to give in terms of caring for others and they might not get there, they might not get to the place of graduating and being a nurse if what we do is always shut down and say...then you ought not be in the program. I think we send a message that's actually really unfortunate to people who had lots to give us (p. 18).

Most teachers chose to be careful about making sweeping generalizations about ANS. These faculty member voiced concerns about labeling ANS into a specific category and acknowledged the importance of getting to know each student as an individual within a broader historical and sociopolitical context.

Faculty #11: I think you have to really work at being sensitive and one of the ways to do it is to engage in a conversation with people to really gauge what's going on...I guess the danger is that all Aboriginal people are not the same obviously as all Non-Aboriginal people aren't the same either. Being sensitive – I think there's a variety of skills involved there. They have a lot more facets to them than just being culturally sensitive. That's a very important piece obviously (p.14-15).

Faculty #15: The interesting thing is there is a lot of diversity between Natives themselves. Some people embrace the traditional ways. They want to know about that. They see it as a way of making themselves more healthy but what was really surprising to me is that there are Native people who are very religious in the Christian faith and they don't embrace the traditionalism. They don't welcome it all the time and there's so much diversity (p. 12)...I think it's really important to understand where some of the students may be coming from, to have a grasp of what does colonization mean, what does that oppression mean, that historical oppression and to understand and I'm still learning about this and thinking about it and trying to work with it. To understand that the person you see in front of you, there's more to them than that because they're bringing, whether they know it or not, they're bringing that historical oppression with them and sometimes the way they may react may be because of that historical oppression too (p 16).

Several faculty members believed that it was more important to address and acknowledge unequal power relations rather than cultural differences. They reminded Non-Aboriginal student nurses and ANS that being a member of a dominant group may create unequal power relations when interacting with clients from a visible minority.

Faculty #17: I will speak more about being aware of someone else's culture and more importantly, be aware if you are a member of a dominant culture. If you do have a culture, it impacts how you act and how you work and so some of the cultural exercises I do, such as the one about let's share some of the traditions about caring for the elderly and I will get some students saying, I don't have a culture. Oh yes you do, let's sit down and talk about this dear. And it is amazing the expression on their face. They go, really! And so then we talk about well look how is this going to affect you as a caregiver? (p. 15).

6.2.3.2 Students' personal agency

Several teachers acknowledged ANS' strong degree of personal agency and determination to succeed despite the odds against them. Their impression of the strength and tenacity that ANS exhibited to progress and graduate as a registered nurse was that it was impressive.

Faculty #17: One thing I wanted to say is that when I get to know students better and learn about some of the social challenges they are facing, I am impressed by their determination to stick with it. Most of my [ANS] have social challenges or social issues that I would wilt under. There is one student who sometimes wasn't turning up for clinical and then we realized that her partner was beating her up and she doesn't want to show up with bruises. There was another person who had her children and her mother in the rental house with her and her mother died over the weekend in the house and she and the kids didn't want to be there anymore so she is trying to find somewhere else to live... So while they were certainly challenges and it could be demanding on them I am impressed that, at their determination and their determination to succeed and I think if we could, if there was a way, well on one hand you know you hate to mollycoddle and take out, pick out one group and say well this group needs particular assistance, there is a part of me that rails against that thing (p. 22).

The following section addresses faculty members' perceptions of unequal opportunities and resources available to ANS versus Non-Aboriginal nursing students.

The first misperception was that ANS were well funded through Band sponsorship. The second perception emerged minimally from the data – substandard primary and secondary education on reserves versus education off reserves. Other perceived inequalities were academic supports and standards.

6.2.4 Perceived inequalities

In a climate where equality and fairness was highly valued, faculty members perceived that several important differences existed between ANS and Non-Aboriginal students. Nursing instructors perceived that ANS were provided with more resources than other nursing students. Teachers expressed their understanding that ANS were well funded by their Bands, and ultimately by Canadian taxpayers. Without acknowledging the contextual component that disadvantaged Aboriginal peoples acquisition of postsecondary education, many faculty members perceived that ANS were actually more privileged than Non-Aboriginal nursing students in terms of funding opportunities and other student resources.

Prior to presenting faculty members' perceptions of unequal resources and opportunities in the student body, I place these perceptions within the context that nursing faculty members valued a climate whereby all students were treated fairly and equally. Many faculty members interpreted that fairness and equal opportunities to all students meant that all students should have the same objectives, course material, resources, and evaluative criteria. Faculty strived to ensure they were unbiased and provided equal resources to every student.

Faculty #3: I believe that they [ANS] are incorporated with the rest. Their objectives are the same. Their assignments are the same. If by some chance, they speak a certain dialect that is very helpful, a lot of praise and that kind of thing is done to build up their self-esteem. But by and large they have to meet

the objectives. It's a generic program and they have to meet what they need to meet (p. 4)... This is a generic program and you have to learn all the bits and pieces, not just Indian health and it has taken her a long time to get through this and I'd say this is the first year that she's actually, in my opinion, progressing with it (p. 7). Knowing the experience that we're having with this one particular person that's already failed one course. We're not doing 1:1 with her. Now it might have been suggested to me in a round about way that that's what we do, but again we've got such a big pot that why would that be fair? So I have my own issues on that and in fairness to all is important to me (p. 19).

Faculty #6: I don't really think that my approach with [the ANS] has been any different than the rest of the students. It seems that they have been part of the group and I haven't thought of them as being any other than your typical students. I think back and there may be some things when I look back and think about it. There may be some things that are different (p. 2).

Donna: What would happen if a student would obviously achieve a satisfactory grade in a clinical course if they were provided with a longer time frame in a clinical area – instead of 12 weeks – 18 weeks?

Faculty #10: I see what you mean. Well, we don't do that kind of thing because we feel like we do it for one we have to do it for everybody. And clinical is a really good example of rigidity, if you want to talk about rigidity... It's very rigid, Donna. It's extremely rigid but we have to... (pp. 12-13).

Although some teachers acknowledged the inequity³⁵ that ANS experienced in financial and academic opportunities, they strived to teach ANS and Non-Aboriginal students in similar manners because of their concern for fairness and equality. I proceed to describe faculty members' perceptions of unequal opportunities in the student body. While funding, academic assistance, resources and differing academic standards were identified by the faculty as being disproportionate, only several faculty members identified that ANS from reserves had different preparation for postsecondary education.

6.2.4.1 More funding

Many faculty members expressed resentment related to misperceptions that ANS were well funded through Band sponsorship. Many teachers believed all First

³⁵ Inequity is unfairness or in this case, bias against ANS as ANS experienced an "uneven" playing field.

Nations nursing students were Band funded and all Métis students were supported by Métis organizations. They were aware of some rules and regulations for Band funding and knew that sustaining Band sponsorship required acquisition of certain academic standards. Most nursing faculty members identified that sponsorship rules designated unrealistic course loads for ANS.

Faculty #6: I 'm quite sure that they [ANS] had access to monies the rest of the students didn't have. I think. Whether student loans, bursaries, that sort of thing (p. 18).

Faculty #3: This is another thing that happens is that they run on a time frame with funding. So they have to take certain courses in order to get funding and this gets sometimes problematic because I don't know what kind of funding they're getting and what they need for this, that and the other thing. So it gets a little confusing (p. 11)...I know this one particular [ANS] on top of all the family problems she's having problems pertaining to financing because the Band was financing her and that was problematic too because the Band councilor would get involved and say cut the finances. So it can have a big impact (p. 12).

Faculty #24: [ANS] certainly have access to another set of funding that general population students wouldn't. Our experience is that students that are funded by their Bands, it depends on what level of responsibility the Bands operate on whether or not that works well. We have some Bands that are very conscientious and so on. We have a common experience with Bands that they don't get their tuition fees paid on time and all this and that causes difficulties for the students. If the tuition is not paid, then they are not technically registered. So for example, we could not take them in to clinical and stuff like that. So there are Bands that have you know, have a history of not being – being slow, being inefficient, and so on with funding. So while the funding is there, it is not always a piece of cake, in terms of the students' financial stuff getting taken care of. So in that regard, I don't know if I could make a general statement. I guess my general statement would be they have access to more funding because of their Aboriginal ancestry then some of the regular students do. Because of the Band funding and because they may have access to Access bursaries that other students don't...I think the perception that they are better funded is probably based in some reality but I am not sure that they are hugely better off...because they have other issues that cancel that out you know (p. 12-13)...So sometimes the funding comes with you know, with provisos that we don't necessarily think are the best for the academic need of the Native student. We run into that a lot, where we feel that the best thing for the student would be to get a rest, take the summer off whatever, well, they can't or they will lose their funding. So they end up have to take summer courses and electives and so on. They are so

exhausted by the time they get back [to nursing courses]. Where they would be much better off to have had that break like other students (p. 14).

One teacher expressed concerns for some ANS who were not sponsored by Bands. She acknowledged that ANS without Band sponsorship (i.e., unsuccessful First Nations applicants for Band sponsorships, Métis students, Non-status Indians) were struggling financially.

Faculty #18: I would see financing as one of the biggest things. That not only Aboriginal students but a lot of students have to contend with. But Aboriginal students especially if they are not Band funded. So we have got, so we have different kinds of Aboriginal students coming into the program. We have got people who are Band funded which is easier for them financially and we have people who are doing it on their own (p. 5).

One nursing faculty member had an experience where ANS demonstrated their reticence to share their bleak financial situations. The teacher noted that ANS were struggling to afford the expense of the taken-for-granted idea of a celebration.

Faculty #13: We always decide to go for dinner because you need that little bonding and that good-bye and we decided to go for dinner and everybody said they were coming and [the ANS] didn't. She didn't say a word. So on the day of the dinner, I went up to [the ANS] and asked her if she was coming and she said, "I don't think so." And I knew why, I thought it was money. So I said, "Is it because you don't have enough money?" and she nodded, so I thought, "Okay, what am I going to do?" So I went to her and said, "I'll pay for dinner and then when I'm up in your community some day, you can buy me dinner, is it a deal?" She laughed and said, okay and then I thought it was very nice. She was telling me as we get changed out of our nursing clothes and put on our street clothes and then the [other ANS] left and they were very late coming to the restaurant... We're waiting for them and then they came in quite late and [an ANS] sat beside me and said we went to [another ANS'] apartment to see if anybody had money. Isn't that interesting? And nobody had any money (p. 26).

Although most teachers perceived that all ANS were funded by Aboriginal organizations, several instructors identified ANS' struggles with limited finances. Lack of knowledge about the context shaping ANS' lives and limited understanding of funding

programs led faculty members to assume ANS were provided with more support than Non-Aboriginal nursing students.

6.2.4.2 More academic assistance

Most nursing faculty members experienced that ANS required more academic assistance than Non-Aboriginal students. Many nursing faculty members were unaware of the substandard education provided to Aboriginal children on reserves. While novice teachers were perplexed about ways to provide assistance to ANS in a culture where fairness and equality were valued, experienced nurse educators embraced the idea of spending time with ANS and learning about Aboriginal communication styles and learning needs.

Faculty #13 (1 year experience as an educator): So for several weeks in a row, [the ANS] stayed with me and she'd give me her patient assessment summaries and we'd go over every single thing and I'd say this is really good, this is relevant, this is what I need, yes, and then we'd get to the nursing priorities and I would say okay when you were caring for your patient, what did the night report? What was it about? Did the night nurse say oh this patient had a terrible night? Had lots of pain? And can you think of something like that or what were you really always going in the room to check on? (p. 12).

Faculty #3 (experienced as an educator): I would meet with her at least once every two weeks and sometimes more often just to, sometimes it was 5 minutes and sometimes it was an hour. I was also teaching her theory at the time so it kind of hand in glove sort of thing and it was easy to work in clinical settings with her to find out what was going on (p. 8)...It's very difficult. It's very time consuming (p. 9)...Their writing tends to be not so great so we have to work ...because not only are they learning English down here but they are also learning the medical jargon which is somewhat problematic for them and they have to understand the proper way of utilizing it, where, when and the charting so sometimes we have to spend a fair bit of time with them pertaining to that (p. 14).

6.2.4.3 More resources

Nurse educators perceived that ANS were provided with more resources than other nursing students. These faculty members viewed the disparity in available resources as unfair to other nursing students.

Faculty #17: But you do know that they do get a lot of extra support and at the same time, as I mentioned I have all these other international students who are not getting all this extra support and you are thinking, "Oh for goodness sake!" (p. 19).

Some nursing faculty members described their awareness that unequal opportunities to access available resources created tension between students in the Access program (mostly ANS) and mainstream students. Mainstream students were perceived as being resentful that ANS had more resources to assist them in their learning.

Faculty #22: There was a lot of irritation between two groups of students because the identification of an Access student meant that you had a lot more supports and then you had free photocopying and you had tutors and this kind of stuff and so that in fact, lots of times really there was no identification. It was better not to know and when I came on board and I don't know if it's any different, we had, I had never had it where I knew who the Access students are. I have never had a list where I have known for sure where the ANS would be... So from 1990 until now, when I talk about ANS, I only know that they are Aboriginal because they self identify (pp. 6-7).

In conjunction with perceiving that ANS were overly dependent on ongoing support throughout their tenure in the schools of nursing, several teachers questioned whether ANS would be able to graduate as independently functioning nurses. Because support would cease upon graduation, faculty members voiced concern that as graduates, ANS would be at a loss.

Faculty #15: Part of my frustration was that my sense that some of the [ANS] ...some of the First Nations students have been so supported throughout their nursing education and given so much support that it seems to me that...I wonder

how capable in the end these students are of functioning as independent professionals when they seem to need so much ongoing support throughout their entire program (p. 16)... So I have some concerns about what we're doing here (p. 17)... They seem to need so much more (p. 18).

6.2.4.4 Skepticism about academic standards

Several nurse educators voiced their concern that academic standards may be lower for ANS. They questioned if "the powers that be" would facilitate ANS' progression even when ANS' marks and clinical performances were deemed unsatisfactory. Faculty members' skepticism was related to the perception that the school was committed to providing more Aboriginal nurses.

Faculty #3: If she has not progressed, and she is progressing right now but if she fails this one course again, she'll be out of the program. That's how it is with everything, every person. So not quite sure what administration would do about that because... they do want her to succeed. So I have been advised to stay on top of her progress and encourage her that if she is starting to drop or fall behind that she be brought up to awareness on that without blatantly saying, "Look so and so, withdraw, because you're going to fail" (pp.4-5).

Faculty #4: Well, I read in the paper that there is a commitment to recruitment and retention of Aboriginal students, yes. I had the sense that there was a predisposition to keeping them in the program and enabling their progress through the program and that their expectation of academic rigor perhaps should be compromised just a bit if necessary in order to get these students completed. I don't know if that's accurate but I did have that perception (p. 18).

In the following excerpt, one nurse educator addressed concern for maintaining rigor in professional practice standards despite being skeptical about lower academic standards for ANS. This educator was proud that the diversity within the student population seemed to match the diversity in the Canadian population.

Faculty #17: I have spoken to other faculty members – [the head of the school] being one of them about I am not going to pass a student just because they are Aboriginal. I am not going to hold their hand. These are my standards and I will do things like, I will pre-read a paper if someone wants. I will spend some extra time with you, but I am not going to change my standards. It hasn't been voiced in faculty much.... I am wondering if faculty are feeling any kind of pressure to

make extra allowances (pp. 18-19)...Now my classes are starting to look like Canada and I am thrilled and I hope the trend continues and we do get more Aboriginal nurses and it makes sense, too. After we recruit, at the same time, we have to maintain the academic standards and that can sometimes be the challenge (p. 24).

In contrast to adhering to academic standards, one faculty member advocated altering rules for a specific ANS. This teacher did not believe that knowledge about statistics would influence the ability of an ANS to practice as a safe and competent nurse. Administrators in the school of nursing would not alter their academic standards and the ANS was unable to graduate and practice as a registered nurse.

Faculty #19: I think the rules can be adjusted as long as you stay within the standards. One of the ANS tried three times to pass statistics and he could not pass that. He went to tutoring. He went to another postsecondary institution. He just couldn't pass it. He had passed every other course in the program so I went to the administration and said, "Could he be given his certificate with the proviso that he had not passed her statistics?" So that is possible in [some postsecondary institutions] to make those kinds of allowances. That was not made. So he spent all those years. He had really really worked...and he's never going to use stats. They would not make that allowance (p. 14)...We really shot him down (p. 16)...I don't ever advocate dropping standards. I think that there's a disservice to people to say we'll make things easier or do things easier. I don't think that's appropriate. But I do think that we need to discover how we achieve a standard that's maybe not identical. The same level but not identical (p. 16).

6.2.4.5 Differences in academic preparation

On the part of several faculty members, ANS from northern reserves were known to be disadvantaged academically in that primary and secondary education on reserves was substandard in comparison with provincially-run schools off reserves. This reality was perceived as a political secret. Although ANS from northern reserves were inadequately prepared for postsecondary education, these faculty members identified that this was not a reflection on ANS' cognitive abilities. These faculty

members experienced a conundrum as to how to facilitate ANS learning when prerequisite knowledge was limited.

Faculty #8: Basically, it took most [ANS] two years to complete each year of the nursing program (p. 8)...The issue of the high school education in the north emerged very quickly as a major problem. We could have had far more students if some of the more critical high school subjects were actually more widely available in northern high schools, but they aren't and I forget which ones there is now but probably, are not readily accessible or available to students and again quality of instruction is probably not what one would wish either (p. 14).

Faculty #19: I think that another thing we need to keep in minds is I think the basic educational program has not been as good – like the elementary and high school. I think that there's a whole issue there that we don't want to discuss or talk about is that they're starting out behind so I think that's an issue. I think that needs to be looked at. The students are just as bright. It's just that we have to be able to pull on that (p. 23).

In a climate where equality and fairness were highly valued, many faculty members (novice and experienced) perceived that more resources were available to ANS as opposed to other student groups. The notion of equality and fairness blurred faculty members' perceptions of the actual inequities pertaining to ANS' experiences. Nursing instructors voiced a strong commitment to equality and fairness when teaching a diverse group of students that included ANS. They were keen to provide all students with the same opportunities, learning objectives, teaching strategies, resources and evaluative methods. When misinterpretations emerged about "more" resources available to ANS, faculty members voiced resentment.

Several experienced teachers identified a tension or disjuncture between what they perceived as academic standards and their desire to facilitate ANS' learning how to become a nurse. These teachers recognized that ANS struggled academically because they were provided with substandard prerequisite education on reserves.

6.3 Translocal context: Where ANS and faculty meet

Here I present faculty members' perceptions of the translocal context beginning with their viewpoints of the student-teacher relationship. Other key factors included in the translocal context were pedagogy, curriculum, class sizes and the school's policies and procedures. When faculty members talked about the translocal context, I began to identify pertinent documents used to organize ANS' experiences.

6.3.1 Student-teacher relationship

When describing the student-teacher relationship, some faculty members voiced their dissatisfaction at not feeling connected to ANS. When nurse educators were placed in situations where classes were larger than 50 students and/or teachers were required to videoconference to distant sites, they expressed concerns of feeling disconnected from all students in their classes. I used the term, culture clashes, to describe instances where teachers were disconnected from ANS in that they expressed that they were truly unable to negotiate mutual understandings.

In contrast to these experiences, several experienced teachers expressed satisfaction at having connected with ANS. When nurse educators were exposed to class sizes less than 50, they were more apt to connect with students and develop more meaningful student-teacher relationships. In the following section, I provide excerpts that describe nursing faculty members' frustration with their limited ability to connect with nursing students and in particular, ANS.

6.3.1.1 Disconnectedness

Many nurse educators expressed their frustration and diminishing morale due to their perceptions of being disconnected with most students. An impetus to teach the

masses overshadowed the importance of establishing a student-teacher relationship, especially when the relationship required time and effort to bridge the cultural clash between Non-Aboriginal teachers and ANS.

Faculty #4: I talked about the sensitive material and sometimes what it is we have to say about [the topic] will trigger some of your memories and some of your experiences and that may be hard for you and if that should happen, please make an opportunity to find some support and they could call me, email me. They could make their contact... but they needed to be aware of this situation and I didn't want them to be alone in that. It was very frustrating because that is the kind of thing I think if you say that kind of thing you need to be prepared to offer some tangible support and I couldn't or I didn't perceive that I could. And I didn't get any responses (pp.2-3)...because I felt so dissatisfied with the experience, really felt that I hadn't reached them and wasn't sure if they grasped the material and all that (p. 6).

Faculty #7: I find here [in a nursing course] still we've been here for 8 weeks and I still do the attendance and there's one group that if I see names I can put them to faces, but all the rest of my groups, one out of nine. All the other groups I look at like the people that I knew prior, I know and maybe one or two others...Well, it's really hard to feel like you're being supportive and responsive to their needs when you don't remember whether or not they were there last week and you can't refer to them by name. They unfortunately are more of a number, a lot of them than not. I'll know that yes, that one's pleasant and that one's sometimes got a little bit of an attitude or something but it makes it difficult in my opinion to create an optimal learning environment in such a thing like [this course] where really that one on one attention is very very helpful (p. 2).

Faculty #11: Here it's different because and especially now because we have classes of 100 and I don't like teaching here at this moment because I feel so disconnected. You're dropped into this room and there's all these beings with you but you're strangers and you're not sure where they come from or where they're going or not sure exactly what you're doing there. You've got this content (pause) it feels so different and I feel very disconnected and that probably shows in the way the content is presented and there's just no sense of connection to the class as a class, to the people within the class to the program. You just feel like you're a little piece of something that's not even connected anymore. It's a very strange feeling. I think that would also get reflected in an individual student's experience or perspective that this is weird. I don't feel like part of something either (pp. 24-25)...I suppose the other piece of that is when students call you from the North and you don't know them. You know that they might be one of those people sitting in the room but you don't know them. There's this real sense of disconnection from these people and that doesn't feel good. No sense of

whether or not what you're doing makes sense to them or have they learned something about nursing (p.29).

6.3.1.2 Culture clashes

In several instances, nursing faculty members had difficulty interpreting ANS' behaviors in clinical practice areas. I refer to these assumptions/misassumptions and interpretations/misinterpretations as culture clashes. Teachers concluded that the ANS' behavior was based upon cultural differences and tried to facilitate a change in the students' actions whereby they conformed to the dominant Euro-Canadian ways deemed appropriate and required behaviors for nurses.

Faculty #4: It was past the time when the medication should have been given and the ANS was at another patient's bedside and so I said to her that she needed to come because we needed to get the medications and she came out into the hall and she said, "But I can't leave him." And I said, "What's the problem?" The patient asked the ANS, "You're not going to leave me, are you?" [The student] said, "And he doesn't want to be alone and it's not right for me to leave him alone." We talked about that and I explained that the consequences of not leaving him alone was that someone else didn't get their regularly scheduled medications for pain and it would mean that someone else would ultimately be in discomfort and she was really perplexed. She said, "I don't know you could ever make that decision because in our way we would never leave someone alone who said please don't leave me." So I don't know how you could work in that situation. It was totally foreign to the student (p. 10).

Faculty #13: One of the things that I thought was interesting was one day was that she didn't show up and there was no phone call and then about 8:30 (we start at 7), there was a phone call for me and it was [the ANS] and all she said was I slept in. Half of me was laughing and the other half wanted to say, "Who cares! Come to clinical." I said okay what are you going to do and she said I don't know what to do. I thought that was very unusual to be a grown woman and not know what to do. That struck me as very unusual. I thought it was a cultural thing. I thought a lot of this was cultural and she came in and then said, "My child was playing with the alarm" and didn't think anything of it whereas another student would have had a hairy canary. She was very blasé about it. Aside from that she came in and she didn't apologize and I don't think I expected an apology from her (p. 21).

When ANS displayed atypical nursing behaviors, nursing teachers met with the ANS and established a contract entitled a performance improvement plan (PIP) to aid the student to focus on changing behaviors to be congruent with the professional culture. Faculty members viewed these behaviors as being necessary to ensure patient safety as established by professional practice standards.

Faculty #13: The first was that [the ANS] never called me by my name. All the students would say, "X, how do I do this?" She never ever did that. If I was talking to you and she wanted to talk to me, she would stand and wait and wait and wait and I would always turn and say, "Can I help you?" and she would say, "I was just looking for this" or whatever but one time, I decided not to turn and say anything and see what she would do and she went away. So I thought that was a very passive kind of thing to do and she ended up having a performance improvement plan put in place because she was having problems and one of the things that we discussed with her was that I need to see you more at the bedside and I said I believe that you need to come and get me. You need to be persistent. I watched her several times just leave and then I'd have to go and get her. I said, "I don't want to do that. I want you to come and get me because I forget" (p. 9).

Faculty #10: She made some really bad errors. An example where she totally disregarded a postop patient who needed something for pain. She didn't know to ask that patient. She just left the patient and again I think that her whole personal life just reflected that she couldn't focus on her work (p. 5)...If you have a surgical patient your priority is going to be pain management but that wasn't the case and again as students become more independent in the 12 weeks you want to leave them alone. You can't be with them all the time. You have to give them that independence. So that student says yes, my priority is pain management. You assume that they're going to take care of that. But then two or three hours later you find out that wasn't taken care of. I don't know why. We only assume it had to have been the family problems...Didn't do any assessing, didn't offer the patient anything and I don't know the whole situation (p. 6).

This faculty member explained that it was not the medication error per se; it was the student's reaction to the medication that concerned her. The teacher interpreted the ANS' reaction as uncaring and unremorseful. The teacher expected students to visibly or audibly demonstrate their concern for the error.

Faculty #13: What I'm looking for is some affirmation that they feel remorseful or worried. You do want something. [The ANS] is not a very demonstrative person anyways and I wasn't expecting her to fall on the floor and start wailing around and I knew she did feel bad but when they make an error they report it and then the first thing you look at is what the medication error was [and the patient consequences] (p. 14)... One student gave Maalox to the wrong patient and she just looked at me like she thought I was going to murder her and I said, "Well there's two things about this med error," I said, "By the time you fill out that incident report you'll never make another one because they're so blinking long and this patient definitely did not have heartburn today." The student looked at me and I said, "It's a med error but it's not the end of the world med error." ... You reported it and I know you feel bad (p. 15).

When teachers interpreted that ANS' behaviors were unchanged, students were asked to withdraw from the course or were provided with a failing grade.

Faculty #13: She had an Aboriginal woman who was dying of lung cancer and this woman had a lot of metastasis and she was on a patch but she was also on Morphine for break through pain and at the end of the clinical day, I said to [the ANS] did Mrs. X have anything for break through pain and the student said no, she has the patch. And I said, "Did she complain of pain anywhere?" And [the ANS] said, "Well, she complained of a headache." And I said, "Did you give Mrs. X anything and she said, "No, I went for coffee." Something happened to me at that point (p. 18)... She was not able to meet the criteria of the performance improvement plan and so I discussed it with another professor and I said, she's not able to meet them and so she got a fail (p. 20).

Access program personnel were available to help clinical teachers and ANS clarify misinterpretations of communication practices. By having an advocate for the student in the clinical area, clinical teachers were provided with clarification of the ANS' intentions and behaviors.

Faculty #18: ...on occasion, we have even had that person go to clinical practice with the students to see if it is a communication thing. Is it totally a lack of knowledge, the inability to do it, that kind of stuff (p. 6)?

Another cultural clash was identified between ANS and the system within the school of nursing. Because many ANS highly valued their family, academic responsibilities often came second. Most faculty members perceived that they were

highly flexible in accommodating ANS' absence or their late assignments due to family or personal reasons. Teachers were empathetic and acknowledged that differing values created a clash or a conflict between Aboriginal culture and the culture of the school of nursing.

Faculty #16: A lot of times with ANS, they will have family responsibilities and complex situations where, for myself I would often put them aside and gone on with my work that I had to do, where what I notice with ANS is their value is that the family will come first and the work will wait so sometimes there's a clash there with that and you can try and accommodate that to a certain degree but sometimes that becomes another conflict with the system (p. 19).

Faculty #18: They are very connected to their families in the north especially, and so the kind of constant back and forth can really hamper them and the family responsibility in that nursing is so heavy that on the weekends, they can't be running back to wherever they came from to spend with their families because there is so much homework to do, and so that can be a problem (p. 7).

In contrast to the feelings of disconnectedness with ANS and other students, several teachers identified job satisfaction when they experienced connectedness to ANS. When class sizes were smaller than 50, a more intimate environment was fostered as teachers were able to employ a wider variety of strategies.

6.3.2 Connectedness

When several local and translocal factors came together in concert, faculty members perceived more connectedness to their students. They perceived that the student-teacher relationship was more conducive to learning. Local and translocal factors, contributing to connectedness, included: (a) faculty members' comfort in exploring a variety of teaching strategies, (b) a philosophy of process-oriented teaching and learning, (c) inclusive pedagogy, (d) smaller class room sizes with (e) curriculum content relevant to Aboriginal health.

Faculty #4: [Meeting ANS face-to-face] It was really positive and I have to tell you for me, it was so much better, I felt that although it was late, there was some opportunities to connect with those people as individuals and it was really important to me. I wanted to have them to my home (p. 7)...One of those students ...has made a habit of dropping in on me. I can not tell you how much I like it. I like it so much and it might be for me and not for the person but it's like an experience in my learning how to relate with...

Donna: How does the visit go?

Faculty #4: Well when I see that person, the first couple of visits I thought that after 15 minutes that was enough and I kind of got on with my work but I learned to slow down and so if that person shows up at my door, first thing I do is look at my watch because I know it's going to be an hour and that person comes in and sits down and we have small talk...After the small talk, I've learned to shut up, which is really hard and I decided I would allow silence and the silence can go on for several minutes but if I wait the student will initiate something more...And sometimes they'll share things that come way out of left field or like their own health concerns or something and I'll think this is the reason for the meeting (pp. 21-22).

Faculty #9: Somebody asked me, "Well, I guess you have to change things for the [ANS] because they take a lot longer or there's content you have to cut." And I said, "Well, I didn't really do that but it might have taken longer to take the concept, break it down into examples that were relevant to the [Aboriginal] community and the Aboriginal culture that were still applicable." You know those principle kinds of things but the examples had to be very focused and then helping them construct it into meaning for them at their level (p. 8)...I think there is a special way to teach them...Did I change the way that I teach?...I did. I changed the way I taught based on a number of things and I don't know if this will get you the equality piece or not (p. 11).

I proceed to describe faculty members' experience with pedagogy. Employing inclusive pedagogy was also dependent upon several key factors within and beyond the school of nursing.

6.3.3 Pedagogy

During my field work and from faculty's transcripts, I noted that many teachers utilized lecture formats to present curriculum content. These lectures occurred in large theatres with over 50 students. In several courses, students were divided into smaller groups to facilitate discussions of case studies or assignments.

Laboratory practice sessions were conducted with 20 students and two instructors. Following a brief presentation and question period pertaining to a skill performance, the 20 students dispersed into groups of two or four to practice the skill. The two instructors rotated among the groups to demonstrate, offer suggestions, and evaluate skill performance.

In several situations, some teachers had less than 50 students in a class and were able to work with smaller groups of students and individual ANS. Within this environment, teachers utilized a variety of teaching methods to facilitate learning. Sometimes nurse educators utilized innovative teaching strategies that worked well with ANS. By relying on trial and error, faculty members located teaching strategies that facilitated learning for a diverse study body.

Faculty #17: I try to use different types of assignments because it doesn't matter, I always have a very wide cultural group when it comes to my students, huge, so I try to use a variety of different assignments because everyone has different strengths and so I will have a couple of multiple choice and short answer tests. Another assignment was a case study. It was a real heavy duty case study and there was a wide range of success on the case study and then on the other assignment I give the students is that I have them interview a woman who either gave birth 50 years ago or who gave birth in a non-western culture, because I have such an international group...And the students have an option to do a presentation of that information if they wish because then they can share it with the whole class, it feeds into the cultural group. Anyway, I found that my northern students loved that assignment. They didn't do the presentation. They all did the paper. But they really excelled. Each found a grandmother and learned about giving birth on the trap line, what it was like, because they interviewed women who gave birth 50 years ago and things were so much different and this is how the birth of a boy was announced as opposed to the birth of a girl and this is the food they ate and this is what the father's role, and they would...And they will write things like, "I am so glad you gave me this assignment and I learned so much and they talked about some pride they felt in learning about this history, this cultural history and just the way they wrote I felt like I really just serendipitously had hit upon a really good learning tool and I think they really enjoyed that because these were students who were getting, some of them were getting Ds on my multiple choice tests and some of them were getting As on this paper and did beautiful work (pp. 10-11).

In the following section within my presentation of pedagogy, I describe faculty members' various philosophies of teaching and learning. While most faculty members embraced a student-focused approach to teaching, their work environment required them to adopt an outcome-oriented approach.

6.3.3.1 Philosophies of teaching and learning

The majority of faculty members voiced ambivalence in their epistemological and pedagogical perspectives. Although most teachers desired outcomes of knowledgeable and clinically competent graduate nurses, they struggled to provide student-focused teaching. Student-focused or process-oriented teaching was reflected when teachers valued facilitating individual's learning processes. I identified a tension that existed in that teachers struggled to balance process-oriented teaching when professional standards advocated outcomes of competency and safety.

6.3.3.1.1 Outcome-oriented teaching

Nursing faculty members voiced a strong sense of responsibility in providing the public with graduate nurses who were knowledgeable and safe in their nursing practice. What emerged from the data was that faculty strived to treat all students the same due to strong intentions of providing fairness to all students. Unfortunately, faculty members failed to grasp the inequities inherent in ANS' experiences such as: (a) historical influences of colonialism and neo-colonialism on Aboriginal education, (b) limited financial support from parents, and (c) current substandard academic preparation for postsecondary education.

Faculty #15: I think as part of their nursing education, they have to understand that we're trying to prepare you for the workforce...I think the expectations have to be the same for all students (p. 23)...But again I need to feel good that at the

end of the program she is going to be able to provide safe competent care to all people, her own included (p. 24).

Several teachers voiced their critique of outcome-oriented teaching. They were frustrated that some of their colleagues viewed acquisition of standards of practice in a narrow way.

Faculty #11: One of the things I think happens is that we're really stuck on this notion if there's one way to meet these standards and it looks like this box and so if you deviate from that then I'm not going to pass you or I don't even want to hear your story. For some people they think that once you get into that territory then you've lost your objectivity as a teacher and this is dangerous and how can I grade you now? (p. 21).

Several faculty members cautioned nurse educators in seeking a prescribed way to teach ANS.

Faculty #16: To me, when somebody says there is a special way of teaching ANS, I think they just have to be careful of what might be the underlying assumption (p. 12).

6.3.3.1.2 Process-oriented teaching

If class sizes were under 50 with face-to-face contact, faculty members were able to incorporate a philosophy of student-focused teaching. This philosophy of teaching created a sense of fulfillment and more reciprocity in the student-teacher relationship. Senior teachers were more skilled and comfortable providing process-oriented teaching.

Faculty #9: It seemed to be more self-directed in a way because you weren't dealing with [large] numbers [of students]...I'd say it was more student-focused...Being the person that facilitates education is different than being the teacher with mass numbers of students so to have that kind of capacity with 50 students requires much more tenacity (p. 3).

Faculty #11: But then I think there are reasons why one ought to pay attention because if they're there and they're sincere about wanting to be a nurse or wanting to learn in the course, I think my job is to help them in whatever way that I can that's appropriate and that meets people's needs. We're not all the same. We don't all learn the same...Now I know that when we have 100 students it's more complicated and I know that those things complicate our lives as teachers but I think that's what I get paid for. I think that's what we're supposed to be

about – a nurse, also. And I say this again not vainly but if as a nurse, I can't care about people then that doesn't make sense to me to be teaching nursing and not understand life constantly gets in the way. But I don't think we ought to write people off because their lives are complicated (pp. 17-18)...Clinical is interesting because our practice is a practice. It's about clinical practice and it's so important. Of course, we want people to be safe and we want them to be competent and how can we be creative about that? (p. 34).

When faculty members explained that they preferred process-oriented teaching, they expressed a sense of guilt that special needs students would require more attention. They perceived that student-focused teaching was not fair in that preference was given to one student over others.

Donna: So I'm just wondering if you have a specific or typical way of teaching ANS.

Faculty #1: That would be different. I don't intend to have a different way. I think that I'm trying to...my experience leads me to maybe try to be more patient around allowing them to, not allowing. Here's what I'm trying to say – sometimes it's harder to get them to come to you to talk about certain things, so to draw them out it maybe a factor that I try to encourage it but on the other hand, I don't intend to treat them differently. I wouldn't want there to be an apparent distinction between how I respond to their questions and I think what might be different is that I know I need to slow down sometimes and just try to convey some confidence in me for them to approach me (pp. 3-4).

The notion of an educational seminar or educational prerequisites for nurse educators who would be teaching ANS was recommended. Several teachers acknowledged that nurse educators required knowledge about the influences of colonialism and neo-colonialism on the Aboriginal culture and epistemology with a wider variety of teaching strategies and evaluative methods.

Faculty #8: Do they have the necessary knowledge to teach students from First Nations background and I would say most people don't....You're going to have to teach differently. You're going to have to be willing to incorporate First Nations spirituality, healing belief practices into the curriculum. So it's a very special area that takes special people. Whether they're First Nations or whether they're Non-First Nations (p. 11).

Faculty #16: I never really started thinking about colonization and what colonization was...I think I really started being aware of that piece and that way of interpreting history when I took a feminist theory course in a graduate program and it was an elective and the professor was very much into looking at marginalized people and the historical picture of that. And that was really, in a way, turned things upside down for me in [my specialty area]...But meanwhile we have a group of people [Aboriginal peoples] who have many health problems to quite an intense level in their population but there is really no explanation of that from the point of looking at colonization or acculturalization. So that really just got me thinking that this is really something and just thinking about the problem in a different way and then from there I tried to incorporate little bits and pieces of that within our time frame, to introduce those ideas to students (p. 3)...I'm thinking about do you treat ANS differently or not. I think it's really important to understand where some of the students may be coming from, to have a grasp about what does colonization mean, what does oppression mean, that historical oppression and to understand and I'm still learning about this and thinking about it and trying to work with it. To understand that the person you see in front of you, there's more to them than that because they're bringing, whether they know it or not, they are bringing their historical oppression with them and sometimes the way they may react may be because of that historical oppression too (pp. 15-16).

6.3.3.1.3 Consequences of outcome-oriented teaching

In the conundrum of delivering outcome-oriented nursing education versus facilitating process-oriented learning, teachers were at a loss as to how to make the learning experience more culturally sensitive and relevant to ANS. They perceived that they failed to balance culturally appropriate teaching with their focus on students' performance of professional practice standards.

Faculty #8: [Developing a variety of teaching and evaluative strategies] I think it's something we do very poorly and really it doesn't matter whether you're talking about a First Nations individual or someone who is from another country. Our understanding of thought processes, sentence structure, how people process information and then communicate. That is very poor and I don't think we do a very good job of helping students with that even though we have [resources] to help students with their writing which I think is wonderful. I can't help but, the students are always being forced to conform to the norm of the dominant culture and maybe that's inevitable but I worry about how it makes them feel about themselves as individuals. Whose skills are second class? Whose culture isn't valued? All of those kinds of issues and it's one where I think we try but we haven't begun to approach finding the kind of answers to that (p. 12).

When nursing faculty members utilized an outcome-oriented approach in their teaching, they were focused on students' achievements of the behavioral objectives. In these instances, nurse educators became entrenched in behavioral objectives and performance appraisals. Several teachers pondered if ANS' apparent mistrust and fear was due to messages that faculty were unintentionally sending to students.

Faculty #9: Because here's a student who has the capacity but there's something that's not in place and I'm not sure how to support that. And I was frustrated and disappointed because the appointment that we made we could have talked about some of those things. This is also a student with a councilor down here who we've never really met. There was a councilor who called and said this student is upset, she's afraid she's going to fail and she doesn't know what to do. This was after the performance improvement plan was in place and so her uncle was sick and so they extended no problem... So we worked with [the ANS] and asking her there's issues that you're having that we can help you with. "Doesn't matter – not your problem, only mine. Don't want to talk about it." So there was not an arena of trust or something that occurred so she could say, "I know I'm struggling right now but I do have this councilor I'm working with." It was kind of confusing. Do we understand the needs? Do we have the resource capacity to manage and help students what their needs are? But I think the big question is do they opt to share that with us and if they don't, why don't they? Is it because of the messages we're sending? Is it because of their experience to date? (pp. 25-26).

As faculty members were responsible to uphold professional standards and ensure all student nurses were capable of safe and competent care, they focused on appraising students' clinical performances. In several instances, faculty members chose to focus on the students' performance rather than the students' claims of racism within the clinical area. Sometimes, faculty members perceived that ANS were shifting the blame to others rather than claim accountability for unsatisfactory knowledge or skill performance.

Faculty #3: Sometimes in clinical they would feel if something was going wrong they would claim the clinical teacher or the nurse or whoever was down on them because of their being Aboriginal, which was problematic and unfair because they were not transferring the knowledge (p.1)...[An ANS] has also had some

trials and tribulations pertaining to transfer of knowledge in the hospital setting, feeling that she was prejudiced against because of her background but again with reinforcement as you would with any person, she recognized that she was making mistakes, rather than blaming other people. That's probably the biggest thing that I've found that I have is that so many of them want to blame and it doesn't matter what color you are, background, anything, they want to blame somebody for their own. And it takes a lot of time and energy to get them to understand that they screwed up. It wasn't the clinical teacher. It wasn't the lecturer. It wasn't the unit assistant. It wasn't the patient. They just didn't have the knowledge and therefore, once they get that, it's kind of like a hop (pp. 7-8).

Faculty #13: [An ANS] did [have a negative experience in clinical]. And she mentioned something about her ethnicity. She said just because I'm Native or she perceived it that way. But I didn't ask for details (p. 34).

Faculty #17: There are students and it doesn't matter what their ethnic background is, if they are a minority and they are not doing well. I have had minority students sit in my seats, in the chair and say "Well, you are just being racist and I am going to see [the head of the school]." "Well, it's a multiple choice exam and you didn't pass. That is not being racist." So that card is sometimes played and I have had another student from up North who I can't remember what reserve she came from, but Mom was on Band Council and she was having great difficulty within the program and it was time for her to be failed and to be debarred and she essentially told me that you can't do this – my mother is on Band Council and I said it doesn't count down here. You are not meeting the requirements. "Well, you are being racist." But you did this, this, and this. That was dangerous in the clinical area and so not with every ANS, but with some students, it doesn't matter what ethnic background (p. 14)... Some of them will threaten that if you fail me, if I am not doing well, then I will put out the race card. They have never gone beyond that with me, because I am very, I'm a nurse – I can document. Try and out document me, kid. I don't say that but it is certainly what I'm thinking. I am excellent at documenting. I do use, probably about half my marks are multiple choice exams. How can I be racist on multiple choice exams? (p. 15)

Several teachers provided their analysis of ANS' claims of racism. Large classroom sizes and process-oriented teaching created situations whereby teachers were forced to be inflexible and rigid with school policies. These teachers expressed that ANS might be confusing rigidity with racism.

Faculty #11: So I think part of our issue is about how inflexible we've been forced to become because of the crunch with numbers. That's not to take anything

away from what you're saying though in terms of how we respond to others and if people are perceiving it as racist, then that's worrisome (p. 22).

Faculty #10: To be honest with you, we are getting very criticized, the school of nursing, we've had a lot of problems with that. Not just Aboriginals, but other groups too that are saying we're not fair, we're racist or whatever because we are rigid (p. 12)...I think that's come through Advocacy many times. But there's many reasons why...There's lots of stories (p. 14)...We'll get back and try to explain to the student that we use an evaluation process, this is the tool we use. We base it on performance just like any other student, not based on the color of your skin or your accent. It's based on whether you can perform or not. It has nothing to do with that. But I still think there is a feeling amongst those students that it exists. I know that (p. 15).

In the following scenario, the clinical teacher found it difficult to label the patient's behavior as racism. The clinical teacher provided the ANS with a different patient assignment to protect both the initial patient and the ANS.

Faculty #13: I assigned [an ANS] an older white middle class man as a patient and he didn't want her as a student. He got very flustered about everything. He made a big deal about everything. [The ANS] was doing absolutely nothing wrong. She was doing what she was supposed to be doing...He didn't want her as a student and his excuse was that [the ANS] had to give insulin subcutaneously and his excuse was that she had really hurt him when she gave it and he said this on the second day that she had given it. I had observed [the ANS] and she had done fine. So he ticked me off. But anything, I said to [the ANS] that you know you haven't done anything wrong, he's kind of a fussy man and going through a rough time so I'll assign you someone else (pp. 7-8).

When nurse educators identified the presence of racism in the learning environment, they acknowledged the historical influences shaping ANS' experiences in the schools of nursing.

Faculty #19: Your students are correct. It [racism] really does exist (p. 9)... And it was the attitude. It wasn't necessarily the words as much as the tone and the whole general demeanor and I think that's really important. You know that old saying – your actions speak so loud I can't hear a word you say. Well, Aboriginal students have had a whole lifetime of picking up on someone's demeanor (p. 23).

Several faculty members addressed policies and resources to promote anti-racism. They viewed these policies and resources as being somewhat supportive to

ANS. In some instances, faculty members described how student resources became involved when ANS or other students from visible minorities claimed that they experienced racism within the schools of nursing. Faculty members were so focused on students' acquisition of behavioral objectives that that failed to assess the entire learning environment to address reports of racism.

Faculty #18: I talk about the X policy [to all students] and I say that you know that harassment of any sort based on race, religion, you know that kind of stuff will not be tolerated in this postsecondary institution and I direct them to the policy and I make sure that if they ever feel that, that they talk to somebody. I haven't had any coming to my attention in the last few years but that does not mean that it is not happening (p. 14).

Faculty #21: They either meet the requirements or they don't graduate and it doesn't matter what culture they are or whatever and we do have to go through very painful appeals where somebody will pull the race card or whatever. But we allow that. It has to happen because we won't graduate somebody, not to say that people haven't graduated that haven't functioned, because you know the requirements for the program have to be met regardless of who you are or what your background is or what your race is and we pay attention to that because sometimes they will fight you, if they are desperate and lots of times their motivation is not our motivation. Their motivation to fight is financial. They just don't think they can afford to repeat again. There may be cultural pressures on them that we don't know and so on. But sometimes when people get desperate, the race card comes out and that's painful for everybody (p. 18)...Because we have had some very hard times with some students who will try that. And its dreadful for staff, nobody wants to be called a racist or whatever and but we fight the battle because you know it has to be fought (p. 19)...So it's not easy to fail Native students because you always know in the back of your mind that this could get into a battle about race, but we just do, because it's the right thing to do (p. 20).

Nursing faculty members used a completely different explanatory model when evaluating application of knowledge and clinical practices of ANS. Because nursing faculty members were so entrenched in their moral obligation to provide the public with safe and competent nurses, their scope of understanding ANS' perspectives was limited. When nurse educators taught ANS in smaller class sizes and relied upon a

process-oriented approach to guide their teaching strategies, they perceived they were able to implement more culturally inclusive education. Negative consequences of being overly focused on outcome-oriented teaching and learning included: (a) being disconnected from all students, (b) job dissatisfaction, and (c) failing to address racism within the learning environment. I proceed to describe faculty members' viewpoints about the nursing curriculum as course content was part and parcel of the translocal context where ANS and faculty members interacted.

6.3.4 Curriculum

The majority of nursing curriculum was geared towards health issues of Euro-Canadians. When Aboriginal peoples and health issues were discussed, faculty viewed this process as inclusive.

Faculty #1: [An ANS] has put up her hand and contributed in the class and in particular, it was relative to when we were talking about surgeries and Aboriginal people having to come from the North. She basically contributed to the class. It was an update for me (p. 10)...Because it's a class about cultural diversity and considerations in surgery, so there was other students as well that talked about growing up in Russia or India and I always make a point, because it's the first class of saying thank you for contributing that information, just as another reinforcement to try and be inclusive but also to get them talking (p.11).

Faculty #7: I guess one thing that made a difference for [the ANS] was that we could refer to her for input about things when we were talking about diabetes for example. I could refer to her and ask her about her family and her community and what she had seen and what her opinions were and how that's affected her because it's hugely directly relevant and if there were other direct cultural things, because I do that with all the students because there are so many different cultural students and it's fabulous to be able to pull from different cultures and ask them to enlighten me because I just personally, aside from teaching the other students, I want to know (p. 11).

In my field work, I attended a lecture for a fourth year theoretical nursing course. The teacher asked the 100 students if they felt they needed to have a guest speaker come to talk to them about Aboriginal health. Many students raised their hands and

expressed that they had received no information about the Aboriginal culture, health beliefs, or health issues in their four years. Students voiced a concern that they would be independently caring for Aboriginal patients soon with minimal knowledge to base their practice upon. In the following excerpt, the teacher described her opinions about the inclusion of information about Aboriginal health.

Faculty #12: I think that 4 hours out of 39 on diversity is the local issue around promotional health in [this province] is not excessive. So I'm thinking that that's the thing to do [schedule the guest lecturer addressing the Medicine Wheel] (p. 10).

While some faculty members acknowledged that Aboriginal health was an important issue within the Canadian health care system, they perceived that it was difficult to add any more content into the existing "full" curriculum. Nurse educators viewed that elective courses about the Aboriginal culture and health beliefs would suffice.

Faculty #18: The other thing that we have done in our program which is really important I think...there are 18 credit hours of electives that the students have to have and 6 credit hours have to be in the humanities area. The courses that we have asked for on site for our humanities are Native Studies...And it is interesting the students either love or hate the courses and the reason why we chose those courses taught as humanities is because we have a high population of Aboriginal patients in [an urban hospital] and we felt that it was important for our students, whether they're Aboriginal or not to understand number one the history of Aboriginal people, especially in relation to Residential Schools, and some of the development of health problems like diabetes and those kinds of things and also the Native medicine and health in relation to Traditional Native Medicine and how that works with medicine today in Canada in the hospitals and how we can get the students to be able to look after the Aboriginal patient in a more holistic manner rather than a white middle class type of waspish kind of way (p. 22).

Faculty #17: I don't think we have caught up to the [changing] demographics. There is a few issues, first of all we have not caught up to the demographics and I think that it just is starting to kind of get to that – oh my, this is something that is missing at the same time, whenever you are looking at curriculum, you don't want to have an additive curriculum where let's pile something else on. It is, "What do we teach and how do we teach it?" I don't. I know that in our new

curriculum, we will be looking at having a Native Studies course but I don't know if it would be mandatory. It would be an option (p. 13).

One teacher excluded relevant information about Aboriginal health issues because she did not want the content or her teaching to be "misconstrued" as being racist. Nursing students in that course were not privy to pertinent information about Aboriginal health issues.

Faculty #17: One of my reasons why I don't do a lot of Native content is that first of all, I don't have the background to do it. Secondly, and I think that this is mostly to cover my ass type of thing. I am really concerned about teaching Native content because what if I say something that offends someone somewhere, what if I come out and make a statement that someone feels is an overgeneralization, is misrepresenting them? And then I am in trouble. So frankly, I will just stay away from it (p. 13)...I really shy away from the culture issue because I could get bitten (p. 16).

I interpreted this faculty member's decision to exclude content on Aboriginal health as a reflection of her experience or perception of intergroup relations within the school of nursing. In particular, the intergroup relations between ANS and Non-Aboriginal teachers. As an outsider, I pondered why the faculty member did not consider collaborating with ANS or other more experienced faculty members (in teaching ANS) to decipher an appropriate method to introduce information about Aboriginal health.

In contrast to the above, several participants felt positive that more information about Aboriginal culture, health beliefs and issues were being addressed. These teachers were optimistic that integration of Aboriginal health into the nursing curriculum would evolve with Canada's changing demographics over time.

Faculty #21: Well for example, [faculty] really encourage Native students when there is projects and things to do if there is something that is particularly, I don't think that I have ever seen any of their health fairs or anything where there hasn't been something that dealt with Aboriginal health in some capacity. And it's often Native students but it isn't always Native students. So it is starting that the and please don't get the idea that we are wonderful about this, it's just evolving that

Aboriginal health issues and the Aboriginal population are part of the norm and that is being built into the ongoing ways we operate curriculum and so on (p. 22).

In the following section about nursing curriculum, I describe how Aboriginal peoples were portrayed within the schools of nursing.

6.3.4.1 Portrayal of Aboriginal Peoples

In my fieldwork, I documented that an ANS had contacted me following her experience after a case study was distributed in a small group seminar. The case study illustrated a stereotypical portrayal of an Aboriginal person living on and off welfare in a subordinate job because of a Grade 3 education. The Aboriginal person was an alcoholic and chewed tobacco. The faculty member later indicated to me that the case study was used to illustrate and stimulate students' discussion about the social determinants of health. After reading the case study, a Non-Aboriginal student singled the ANS out as she said, "You're Aboriginal. You should know the answer."

The teacher, who utilized the case study, did not perceive that the ANS was offended by the way that an Aboriginal person was illustrated in the case study. The teacher interpreted that the case study motivated the ANS to share how Isaac's life was similar to the ANS' life. The teacher interpreted that the ANS wanted to share her experience of the consequences of colonialism and neo-colonialism and the actualities of life on a reserve with the Non-Aboriginal students in the class.

In subsequent interviews, I provided teachers with a hard copy of the story of "Isaac" and asked them to read the case study and share how they perceived an ANS would react to this assignment. Most teachers acknowledged that ANS attending that class would require preparation and debriefing for this case study and suggested that another more appropriate case study without identity of race or culture would suffice to

achieve that particular educational goal. These faculty members shared their insights into development of more inclusive teaching strategies.

Faculty #15: What I try and do with the First Nations students as I would with any student is always acknowledge their ethnicity and treat them with respect. I try to - where possible, incorporate videos or case studies that will positively reflect on First Nations people (p. 3)...For the students up north when I give them a case study assignment, I try to make it relevant to situations that they would encounter in the north so that they can relate to the case study and then it fits well with all of them whether they're First Nations or not and I don't come out and identify the individual in the case study as being First Nations but I try and make the case study read such that they have a feel for the fact that this person may be working in the bush or was fishing, trapping, has a large extended family. Those kinds of issues that they can connect with (p. 4)...I wouldn't use a case study that portrays someone in a negative stereotypical way like this because it really is offensive - even if this is in fact one true case (p. 7).

Faculty #11: The question - what caused Isaac's death is a very profound question...It's very interesting because this is very clinically written in a sense that it's a real removal from Isaac. It's as if we're all standing outside of Isaac and watching this unfold in a very clinical kind of fashion and how useful that kind of approach is a very interesting question. It would be interesting to know what the person thought they would be accomplishing by presenting this kind of case and I think again asking an interesting question if it was moved from the story you're presented with...One might wonder how Isaac managed to survive as well as he did for as long as he did. That would be a more interesting question. And Isaac could be anybody in this instance (p. 12-13)...Going back to the story of Isaac, wouldn't it be interesting to talk about Isaac as a person. So tell me about Isaac, the person. That wasn't what the case was about. It was about something else, but let's talk about Isaac as a person. Wouldn't that be an interesting way to look at one's life story and what happened to them and explore why is that? And how did people contribute to how Isaac's life was shaped? That would be an interesting exercise, I think (p. 36).

When students were preparing to venture into clinical and community placements, some teachers provided them with information about cultural differences in communication styles. These teachers perceived that it was more beneficial to have students grasp a general knowledge base of communication styles in certain cultures and then progress to the importance of assessing individual's communication styles.

These teachers wanted the students to gain further understanding that there is more diversity within cultures and that difference does not translate into "bad."

Faculty #17: We do some cultural - a little bit of lecturing of working with Native clients because it is one of their first courses and hopefully give them some idea and I will talk to the class about things like eye contact, etc. because I remember when I was a brand new grad, I remember going in and speaking to Aboriginal patients. I had no idea as to this eye contact issue and I would be trying to look at their eyes and they would be looking at the floor and we were both thinking that the other was really rude and it gave the class a bit of a chuckle but it really points out that be careful what you are doing and know your clients, no matter what the culture is (p. 10).

Faculty #16: The interesting thing is there is a lot of diversity between Natives themselves. Some people embrace the Traditional ways - they want to know about that, they see it as a way of making themselves more healthy - but what was surprising to me is there are Native people who are very religious in the Christian faith and they don't embrace the Traditionalism. They don't welcome it all the time and there's so much diversity (p. 12).

Faculty #12: So I think it's time we learned about some of the strengths of societies have to offer as well as just labeling them with their morbidity from the medical model because it doesn't seem to me when you pick up a textbook you would read all those stats about morbidity. My understanding is that most people want to normalize rather than abnormalize and so if I was an Aboriginal person sitting in class and they were telling me 20% of the population has diabetes....and that's a pathetic way of presenting it...How come they're still here? How come we haven't killed them off if we've done that much. So I think it's time we started looking at them from a strength and trying to learn from them instead of trying to teach them (pp. 10-11).

I proceed to briefly describe faculty's perceptions of how larger classroom sizes constrained their abilities to provide process-oriented teaching and connect with students.

6.3.5 Classroom size

The data indicated that a major concern for teachers was larger classroom sizes, specifically relating to the larger student: teacher ratios. Faculty members acknowledged that the nursing shortage created a situation whereby they were

responsible to graduate a higher number of nurses to provide health services to the public. When teachers were responsible for a large number of students, they were limited in their abilities to provide process-oriented teaching and a more intimate learning environment. Some participants perceived they had no choice in accepting increased workloads and larger classes.

Faculty #11: Sometimes we don't have a choice how things unravel or progress but the class sizes, the increased work load, the constant turnover of staff, the building, our disconnection from each other as faculty members. All those things I think change the way that we are in the classroom to the negative I think those are external pressures that some of them we have no control over at all (p. 26).

Faculty #15: Morale is very bad. The issue of class size...Once the numbers got above 75 and up to 100 or 120 I just can't anymore (p. 30).

Faculty #16: ...when I teach in nursing now there's so many people in there, like 100 or whatever in the room so I never get to know the students really closely (p. 7)...Well, I think it works better in small numbers for sure (p. 13)...What happens though in nursing, in our classes right now, you can have some humor but everything is so structured when I'm thinking of the big theory classes that we have and being able to accommodate differences in people is getting harder and harder to do (p. 18)...I think we have to understand that [influences of colonization] affects how they receive education. I think we have to understand that to a certain degree but I think there is a kind of inherent conflict with a big institutional machine and this big schedule and now larger and larger classes – how do you – you don't get to know students first of all. So that's a big thing and how do you accommodate that when you have say 120 students. So there's some tension there with that. The other thing is humor with the students. They appreciate that. We lose that in these large classes, too (pp. 20-21).

Within the translocal context, faculty members discussed the student-teacher relationship, pedagogy, curriculum, and their concern with larger classroom sizes.

Documents, policies and procedures within the school of nursing also shaped where ANS and teachers met. In the following section, I describe documents, policies, and procedures that faculty members perceived to organize their work with ANS.

6.3.6 Documents, policies and procedures

Teachers referred to certain documents and school policies when they discussed their work. Again, faculty members perceived that rules and regulations were in place to ensure fairness and equality to all students at all times. Pertinent texts within the school of nursing were identified as: course syllabi, performance improvement plans, clinical evaluation forms, failing a course, and rules about students permanently exiting the program.

6.3.6.1 Syllabi

Faculty members relied on the course syllabus to convey the rules and regulations about specific nursing courses to the students. Faculty members followed these rules and regulations to achieve equality and fairness to all students.

Faculty #7: It's right in the syllabus that you can have an excused absence or if you have unexcused absences that you lose this many marks off your professionalism marks so that may have something to do with it (p. 18).

Faculty #10: I read through that syllabus and tried to follow that evaluation tool and I think I did well as a [clinical teacher] (p. 16).

Teachers and students used the course syllabus as a directive to convey the course objectives and describe assignments used to evaluate students' academic and clinical performances. Although clinical teachers found that many assignments related to the clinical courses were counterproductive, they felt powerless in their ability to implement a major change to decrease the students' workload. In the following example, a teacher sent a mixed message about the requirements for reflective journals to an ANS.

Faculty #13: ...students have to turn in research articles. Those poor students, as if they don't have enough, every week that have to turn in...

Donna: Why?

Faculty #13: Well to torture them? Who knows? Well, they have to run in research articles relevant to their patient.

Donna: Who would have the time?

Faculty #13: I know and you know what? They have to. It's part of the curriculum, part of the requirement... They either have to do a clinical presentation, they have to do a research article and they have to turn in these patient assessment summaries which are 6 sheets on each patient and don't forget at the end of clinical, they have 3 patients each.

Donna: What's the point of all these assignments?

Faculty #13: Well, that's what [the students] they asked me and I say to them, let's face it... They thought it was stupid and they have journals that they have to turn in. Four journals and the criteria for the journals is very strict. The journals are reflexive. They're supposed to be reflective on the nursing process. You know what? I told them they could write anything they want... [The ANS'] journal – I'm trying to remember what she wrote. I remember, [the ANS'] journal was depressing. "I will never be able to do this. I'm having so much trouble. This is such a problem. I can't understand this"... I brought it to her and said I don't want to hear this (p. 30)... Even the clinical seminar presentations, I thought it was overkill... It's a stupid system (p. 40)... When the postsecondary institution says you must do this, I do it. I said, they're my boss and they want me to do this, so I'm not going to rock the boat and I'm going to do my very best (p.41).

6.3.6.2 Performance improvement plans

Teachers developed and documented performance improvement plans (PIPs) when a student's clinical performance was evaluated as unsatisfactory and certain areas required immediate attention. PIPs were viewed as contracts established between the teacher and the student and listed behavioral objectives that the student was required to accomplish in a specific time frame.

Faculty #13: So we put this thing in place with a number of parameters that she had to meet. She will complete care safely on time. Complete charting appropriate. She will assess pain levels on all clients that were administered. She will give medications on time. She will demonstrate understanding of medications she has to give by reviewing. She will hand in patient assessment summaries which are completed appropriately and her priorities and interventions will continue to be appropriate and she will see out the clinical teacher for concerns... And she came very willingly to discuss this and she signed it very willingly... and she was very quiet through it all and I felt terrible. We read through it and I told her what my concerns are and what I noticed and she would say things like she would make allusions about the difficulties she was having in her personal life (pp. 18-19)... She was not able to meet the criteria in the PIP and so I discussed it with [another faculty member] and I said, she's not able to meet them and so she got a fail (p. 20).

Several teachers were perplexed why ANS appeared threatened by the implementation of PIPs and subsequent meetings to discuss the clinical teacher's evaluation of the student's clinical practice. These faculty members chose to see PIPs as supportive and helpful in that the document was easily understandable (to the teacher) and would assist the ANS in focusing on specific knowledge, skills, and behaviors.

Faculty #9: There was a med error that was made. It was considered by the clinical teacher to be very minor but still it was the processing of the task, the principles behind it that she didn't prepare for. That was different. And now we're going to be in a battle because that means she's failed the entire course. We've looked at ways to support and help her get organized and structured when we did a performance improvement plan. She became very angry and defensive and the day to day [clinical course teacher] and the clinical teacher sat down and talked with her about it. I was called in because she was so angry and she wanted to talk to someone in a higher level. I made an appointment with her the following day, 3 hours after the appointment time, she phoned and left a message that she forgot she had an appointment with her doctor and didn't ask to reschedule. I wondered at the time what was going on and I got frustrated that she didn't show up (p. 24-25).

6.3.6.3 Clinical evaluation forms

A clinical evaluation form was included in the syllabus for clinical courses. Most teachers had conflicting views about clinical evaluation forms. On one hand, clinical evaluation forms were described as objective tools to document students' knowledge application and skill performances in clinical and community health areas.

Faculty #13: By the time we got the final evaluation, she slipped to an unsatisfactory (p. 15)...I don't know because when I look at her midterm, her midterm, her assessment skills were satisfactory. Final was unsatisfactory. Planning was satisfactory, final was unsatisfactory. Implementation was good and then it dropped to unsatisfactory. Her final evaluation she just gave no insight into why her care was late. She had no insight into why she continued to be reminded to complete charting. Her assessment summaries were erratic in content (p. 23).

Students received documentation of the teacher's evaluation at least twice during a 12 week clinical rotation. On the other hand, teachers acknowledged that students perceived clinical evaluations and the clinical evaluation forms as lacking objectivity.

Faculty #10: When you're having that much problems you try and ensure you talk to the students. There's always a midterm evaluation and then there's a 9 week letter and then twelve weeks (p. 3)... Clinical as you're learning is a really difficult course to evaluate students and the students don't like the evaluation. They think it's too subjective. We try and keep it objective and that's why we show the students this is where you are and this is why you're at this grade and this is why you're not satisfactory because you're not doing this. We try and use that form because we want everybody to be the same. We want all [clinical teachers] to be consistent. It doesn't matter who you have. You have the same form. So we try really hard on that (p. 15).

6.3.6.4 Passing a course

Faculty members described grade criteria for passing/failing a nursing course. Criterion for passing was a letter grade of C. PIPs and midterm evaluations would be in place prior to a student receiving a failing grade in a clinical course. Passing or failing a clinical course was based upon the clinical evaluation form.

Faculty #11: The notion of failing clinical is very interesting, isn't it? (p. 33).

Faculty #9: [This ANS] failed the [clinical] course because the requirements are you have to pass each rotation with a C in order to pass the whole course. She actually got a B in the first rotation. Maybe could have been a C+ but they're coming in and you're working with them in that 6 week period of time and noticing things (p. 27).

6.3.6.5 Leave of absences

Sometimes ANS were required to apply for a leave of absence for personal reasons. Other times, faculty members suggested that ANS take a needed break from school to attend to other life issues. Leave of absences were viewed as temporary exits or "pit stops" to facilitate ANS' attendance to family or personal problems.

Faculty #18: If I can prevent them from walking away [from nursing education] because of a personal crisis and do something like take a leave of absence rather than just kind of wander away from that, sometimes what the student will do is that they will end up having a personal crisis and they just don't show up and what I try to do is write a letter asking for a leave of absence rather than just walking away because if you walk away without going through the proper channels, then you get F grades and everything and that ends up following you for the rest of your life (p. 28).

All students had 10 years to complete the program. Several teachers normalized the issue that ANS would require longer periods of time to successfully complete the nursing program. These faculty members appeared to accept ANS' longer tenure as a "given." Others voiced their concern for the longer tenure and equated the longer tenure with an easier less rigorous academic flavor resulting in the ANS' inability to learn how to become a safe and competent nurse.

Faculty #22: I guess one of the practical things that has become a normal here for us is that it's quite common for the Access student to take more than 4 years to get through the program and we expect that. It's not considered abnormal or you know something bad, you know they voluntarily withdraw. They have to repeat courses and so on...but they get it done. And so it's just normal. You don't expect that the majority of them will make it straight through in 4 years and that's just reality, so its part of the way that we operate (p. 7)...We try to build the belief that going through in 4 years is not necessarily the norm and that it's normal when you have social stretches and you know, you have worked hard in academics and so on, that you will not take it in that and you are not made to feel that there is something wrong with you because you are not able to just go 1, 2, 3, 4 years. Instead we sort of try to normalize the process of it taking longer than 4 years for access students so it's not seen as a failure for them to do that (pp. 11-12).

Faculty #15: I am thinking of one ANS now...she's probably been in the program now for 7 – 9 years. She takes a course...Well, she's voluntarily withdrawn so many times...She would start a course, miss classes. Either she would fail or take it again or he would voluntarily withdraw. You can now drop courses up to about week 10 in the program so they can essentially go through 10 weeks of a course and drop the course without academic penalty (p. 23)...But again I need to feel that at the end of the program she is going to be able to provide safe competent care to all people, her own included. Now yes, she will have to write the RN exam and so that is a screening tool right there (p. 24)...So here's a person who in her mind thinks she's going to go back up north and work in a

nursing station and do acute care and she really may not be suited to providing that kind of care and so when she would choose clinical placements perhaps she was barking up the wrong tree and it took a long time for them to guide her and find an area she would be successful in (p. 25).

6.3.6.6 Permanent departure

Nursing faculty members explained that upon failing a theoretical or clinical nursing course two times with a Grade of D or lower, students were required to permanently leave the program. If a student failed a nursing course, they were encouraged to repeat it. However, when students repeated the course for the second time, they were required to achieve a satisfactory grade (no lower than a C). If students failed the course a second time, they had to leave the school of nursing. In most cases, teachers described the difficulties students encountered in third year medical/surgical nursing courses – theoretical and clinical.

Donna: What would happen to the student if she did not meet the objectives?

Faculty #3: Then she would fail and then she would be removed from the faculty. That is what happens with any student. If they fail a course twice. I would probably suggest that she would have to regroup, reapply and I have a feeling, they'd let her back in after (p. 12).

Faculty #17: If you fail twice then she is out of the faculty, so she has to pass my course this time. Now there is a lead up time before which they can voluntarily withdraw, so if she gets an exam back she will have an exam and a case study, she will have about 40 – 50% of her marks before voluntary withdrawal so she can choose, if things aren't looking good, she can drop (p. 12).

Faculty members identified important inter-related features within the school of nursing or the translocal context. These inter-related features influenced the teaching and learning process: (a) the student-teacher relationship, (b) pedagogy, (c) curriculum, (d) student: teacher ratio, along with (e) documents, policies and procedures.

I proceed to present faculty members' perception of outside influences on ANS' experiences. Teachers acknowledged that several key factors in the extra local context shaped the process whereby ANS learned how to become a nurse.

6.4 The extra local context: Outside the school

First and foremost, nursing faculty members were keenly aware that professional nursing standards highly influenced how faculty members taught and evaluated students' knowledge level and skill acquisition. Secondly, the nursing shortage was cited as having influenced higher intake and larger classroom sizes as there was a public need to graduate more nurses. In the third place, teachers perceived that political and bureaucratic inefficiencies in Band sponsorship wreaked havoc on ANS' finances. Finally, support or lack thereof from the Aboriginal community was cited as an external factor shaping ANS' experiences.

6.4.1 Standards of practice

Professional practice standards were acknowledged as key guidelines shaping faculty members' expectations of ANS' knowledge acquisition, knowledge application, and skill performance. Professional standards were perceived to govern objectives of theoretical and clinical courses. Nurse educators were morally bound to ensure that all nursing graduates achieved entry-level practice standards.

Faculty #17: I am not going to pass a student just because they're Aboriginal. I am not going to hold their hand, these are my standards and I will do things like, I will pre-read a paper if someone wants. I will spend extra time with you, but I am not going to change my standards (p. 18).

Several nurse educators referred to the RN licensure exam as a stop-gap that ensured that graduates' knowledge level was satisfactory enough for them to provide safe and competent care to the public. All teachers expressed a moral obligation to

ensure that the public was safe by not passing students deemed lacking knowledge, competency, and safe practice.

6.4.2 Nursing shortage

While most faculty members acknowledged that the nursing shortage affected an increased intake of applicants and larger classroom sizes, no faculty members questioned why there would not be an increased intake of faculty to accommodate more students. Only one teacher analyzed the current situation as a reflection on the notion that nurses as a group, were disempowered and overly accommodating.

Faculty #12: Well, it's government driven. Nursing across the country has always decided to produce whoever the government says they want. Physio doesn't do that. OT hasn't, medicine hasn't and they do what they can. Nurses themselves are oppressed so that whole oppression cycle – we're probably bigger oppressors because we're oppressed ourselves (p. 20).

6.4.3 Band influences

Several teachers were aware of inconsistencies and instability of Band sponsorships. They acknowledged instances when ANS experienced the Band's removal of funding with devastating consequences in that ANS could not continue in the nursing program.

Faculty #15: ...then there were some threats from her Band that her funding would be cut off. She was very distraught. She was already into her fourth year and she didn't know what to do and she felt like her whole future was in jeopardy (p. 33).

Teachers described how Band sponsorship policies and "pressure" from the Aboriginal communities prevented ANS from taking needed leaves from the school.

Donna: Do you think that it would be an option for her to exit the program and then come back when things are straightened out?

Faculty #3: That's what I suggested or I asked her. And that wasn't an option. Because the Band was financing her and there was a great deal of pressure...and so she had a time frame and she's had to go back to argue her

case a couple of times now because she has not been successful in some courses. So she is moving slowly through, just like the other ANS...(p. 22).

6.4.4 Expectations of Aboriginal community

Teachers perceived that members of home communities were carefully observing ANS' grades and performances. Faculty members acknowledged that ANS probably perceive that they have a huge responsibility to achieve because of the Band's expectations and high value for acquisition of postsecondary education. Other teachers interpreted that ANS might be scrutinized by members of their community because they were outsiders and now different.

Faculty #3: The funding though doesn't come out of people's pockets per se, it comes out of the community pocket rather than the individual pockets that it comes out with the [other nursing] students...How can I go back when I haven't done well? (p. 16).

Faculty #17: Perhaps the key is to not only work on what we're doing in the faculty, but also to work on what is happening in the home communities and I don't know how to do that. If they could have some kind of stability and what type of support is there within their family? Are there dynamics happening in the family in terms of jealousy or you are really white inside or whatever? What else happens that is impacting on their experiences as well? (pp. 23-24).

Faculty #18: And the Aboriginal community is putting a lot of emphasis into students getting an education (p. 11).

6.5 Chapter summary

In this chapter, I presented faculty members' standpoint. The majority of participating faculty members was white middle-aged women with university degrees and more than five years experience in nursing education. Although many teachers acquired minimal preparation to teach ANS and perceived that they had limited experience teaching ANS, several teachers proactively acquired information about the

Aboriginal culture that was incorporated into development of inclusive teaching strategies with ANS.

Faculty highly valued equality and fairness to all students. Faculty members expressed resentment when more resources and flexibility were perceived to be available to ANS in comparison with other student groups. Perceived inequalities were related to faculty's interpretations of financial, academic human and physical resources, with skepticism that academic standards were lowered to accommodate ANS. When nursing faculty focused on inequalities versus inequities, they lacked information about the historical and sociopolitical contexts that negatively influenced ANS ability to enter and stay in nursing education on an even playing field.

Nursing faculty members shared their varied philosophies of teaching and learning. All teachers were bound to uphold stringent professional practice standards with a deep responsibility to the public to ensure safe and competent graduate nurses. However, most teachers identified personal fulfillment and job satisfaction when they were able to embrace process-oriented teaching. Constraints to adopting a process-oriented philosophy and student-focused approach were identified as the privileged positionality of faculty members, larger classroom sizes and videoconferencing for distance education. Negative consequences were feelings of disconnectedness to all students, resulting in job dissatisfaction and poor morale.

As most nursing faculty members were focused on ANS' academic and clinical performance appraisals, they frequently ignored ANS' claims of racism within the learning environment. Most claims of racism were not explored or investigated further

by faculty. Differences in explanatory models about nursing knowledge and clinical practice created culture clashes between faculty and ANS.

In terms of pedagogy, most teachers used a lecture format to accommodate the large classroom sizes. Several faculty members shared their positive experiences using inclusive teaching strategies.

Although the nursing curriculum focused on Euro-Canadian health, several faculty members perceived that information about Aboriginal culture and health were being introduced. Faculty members called upon ANS to share their perspectives about Aboriginal health issues in large classes and small groups, thinking that this strategy was inclusive.

Schools of nursing responded to the nursing shortage by increasing enrollment with a limited increase in faculty members. A higher student teacher ratio and larger classroom sizes constrained faculty members' abilities to fully embrace process-oriented or student-focused teaching. Pedagogy was affected in that the teaching formats were often limited to lectures that negatively contributed to limited student-teacher interactions with class sizes larger than 50 students. Large classroom sizes created situations where teachers were unable to get to know their students' names, let alone their needs and learning styles. Teachers expressed discontent and job dissatisfaction in that they felt disconnected from all the students, and in particular ANS.

Pertinent documents, policies and procedures organized the experiences of ANS. These documents, policies and procedures included course syllabi, performance improvement plans, clinical evaluation forms, pass criteria, leave of absence and permanent departures. Many nursing faculty members perceived that several forms

were objective documentations of students' clinical performance. They perceived that the performance improvement plan was a negotiated contract between the student and the teacher. While most faculty members relied upon the clinical evaluation form as an effective tool to objectively document students' skill performances in clinical or community practice areas, several teachers identified the subjectivity involved.

Faculty members identified that outside influences also shaped ANS' experiences. These extra local factors were professional practice standards, the nursing shortage, Band influences, and expectations of the Aboriginal community.

7 KEY INFORMANTS' VIEWS ABOUT ABORIGINAL NURSING STUDENTS' EXPERIENCES

I think there are issues there that are much more serious and more problematic than we imagine. I think we sometimes take for granted that we've done so many things in the Access program etc. and our faculties **are** racist...I think we take for granted the situation is easier than it really is and I think the depth of discomfort sometimes with the system is a lot more profound than we realize and in some ways the kind of project that you're doing – people are probably reading it on several levels. They're saying is this really an opportunity to get to the bottom of this to get to the truth or because of the nature of the project is it likely to be difficult for me to really talk about the things I'm worried about and if I can't talk about them then why should I waste my time doing it? (Key Informant #5, p.5).

7.1 Introduction

In this chapter, I present the findings of key informants' perspectives of factors shaping ANS' experiences. Key informants (KIs) were recruited based on their knowledge and experience about the wider social context shaping ANS' experiences. Sixteen KIs participated in a one-hour audio-taped face-to-face semi-structured interview about their situated viewpoints of the local, translocal and extra local context that shaped ANS' everyday world. On two occasions, a pair of KIs chose to be interviewed together. The positionality of KIs and their knowledge of the context shaping ANS' experiences provided a broad scope to examine how factors inside and outside schools of nursing influenced the educational tenure of ANS. KIs viewed that factors in the local, translocal and extra local context sustained an "uneven playing field" for ANS.

To protect the identities of KIs, I simply refer to them as KI #1, #2, #3 etc. I do not refer to them by position, role, or experience. I proceed to share the information about the historical context in that several participants were knowledgeable about the evolution of recruitment and retention of Aboriginal peoples in nursing education.

I present factors shaping ANS' experiences by organizing them into local, translocal, and extra local contexts, reflective of the standpoint of the majority of the KIs

who were located 'outside' the schools of nursing and looking 'in.' However, two KIs were located 'inside' the schools of nursing as I conducted interviews with two nursing students who were members of other visible minorities (in the school of nursing) to compare and contrast their experiences to the standpoint of ANS. These students' perspectives of the translocal context validated some of the experiences of ANS.

7.2 Broader historical context

KIs offered further information about the history of Access programs and other entrance avenues for ANS. When Access programs were initially developed to recruit more Aboriginal peoples into health care professions, schools of nursing situated in university settings did not participate in the initiative.

KI #1: Okay, originally the first student support program began in 1975 (p. 2)...In 1979, they noticed that there weren't very many Aboriginal people in medical professions. Yet, a lot of Aboriginal people were being treated through the hospitals and especially in the northern communities where they were sending white doctors up to the north to treat huge groups of Aboriginal people. So they decided to begin a special pre-medical studies program. Now that program started in 1979, was aimed at just Aboriginal people and that program was developed just to answer that question or assist those students in getting medical degrees, that being pharmacy degrees, medical degrees, dentistry degrees or physiotherapy degrees – assist Aboriginal groups going for those degrees.

Donna: And nursing wasn't in there then?

KI #1: Nursing wasn't in there at that time. Nursing's always been a [postsecondary] program that's sort of always fallen between the cracks at the [postsecondary institution] in a way, at least in access (p. 4).

KI #10: They do have some programs that focus specifically on Aboriginal people and that it is to increase the numbers into certain programs and there were programs that were specific to Aboriginal people in the field of education, particularly around the change to the curriculum making it more focused on something that met the needs of the Aboriginal community so that was one of the early programs. Interestingly, nursing didn't become one of the focus programs until much later but the professional health program, which was a focus on as I indicated medicine, all of the other professional medical stream programs, professional health, dentistry, pharmacy, med-rehab was one that was specifically for Aboriginal program. There was also focus programs in engineering and then later on in nursing, social work as well (p. 5).

Several KIs was aware of the historical context regarding financial support to Access students. Originally, students in the Access programs were adequately supported by provincial funds, whereas, currently students in Access programs are known to be struggling financially.

KI #11: I think that when we started the special premedical studies program in 1979, many of those things were built in. There was a recognition that these students have to live comfortably and you have to provide enough financial support that they weren't stressed about their next meal. They weren't stressing if they needed tutoring, almost uniformly and that was provided. I think we slipped away from that. I think the view is now that there are some things that are provided – Access and others that are left to their own devices...Traditionally, in [this province] we have been a little more sensitive to try to improve access of those who wouldn't otherwise have access and use the access program that way. Well, those are the very people that need a lot of help. So you seem to loose track of that (pp. 3-4).

A few KIs voiced their concern that provincial governments were only verbally supportive of access programs and recruitment and retention of Aboriginal peoples in postsecondary institutions. In their lengthy and combined experiences, funding was extremely limited to both Access programs and students.

KI #1: In words, they're [the provincial government] very supportive. They give us great lip service...They've always, when they got elected in, one of their things they stood, their platform was, "We're going to do something for the Access programs. We're going to help them out. This is a great program." And they keep telling us and we already know that but they keep reiterating it and telling us how they're going to support us and yes, they have given us support. They've given us far more support than the previous three [provincial governments]. However, they have not given us enough support. Things could be worse but they could be a heck of a lot better....Between the years 1993 and 2000 our program never experienced an increase in our baseline budget but yet everybody's salaries here increased but we don't have an increase in our budget so what actually happened was salaries started to erode the services we could offer the student (p. 27).

This perspective was congruent with ANS' experiences whereby personnel in access programs appeared overburdened and busy with others' concerns, limiting time spent with ANS.

In the following section, I present KIs' perspectives of ANS. In particular, KIs provided their insights into how local factors influenced ANS' experiences of nursing education. KIs described previously identified factors such as lack of prerequisite education and the need to readjust to urban lifestyles and large postsecondary institutions. Distinctive perspectives of KIs included their insights into inner conflicts that ANS might experience. KIs offered additional insights into ANS' experiences with cognitive dissonance as ANS may hold conflicting beliefs about education, nursing and the health care system.

7.3 Perceptions of Aboriginal nursing students

From the standpoint of KIs, previous educational and life experiences influenced how ANS experienced their nursing education. KIs' perspectives supported previous findings: (a) limitations in primary and secondary education for children on reserves, (b) culture shock in adjusting to city life and urban campus. Unique perspectives lied in KIs' insights that many ANS learned the necessity of critical thinking to survive previous life situations. Several KIs pondered the notion that ANS might experience cognitive dissonance³⁶ as some ANS would most likely experience conflicting beliefs about health and nursing.

7.3.1 Critical thinkers

KIs acknowledged that most ANS were mature individuals with previous life experiences that required ANS to develop skills in critical thinking. Several KIs viewed that schools of nursing were intolerant of critical thinkers.

KI #2: That's what I find frustrating about nursing – that the opportunity for real creative thinking is so limited and people who try to be creative are penalized because there's a certain way of doing things and that includes how you look,

³⁶ Cognitive dissonance is defined as a psychological phenomenon that occurs when there is a discrepancy between what a person believes, knows, and values and information that they receive that calls their beliefs and 'known truths' into question. The discrepancy causes psychological discomfort and the mind is required to adjust to reduce the discrepancy.

how professional you look, if your shoes are white, how you interact with patients. That isn't as prescribed I don't think – from my clinical experience I don't think it was as prescribed for any other health care professional as it was for nursing. I don't remember the OTs [occupational therapists], PTs [physiotherapists] having those kinds of... They had their job to do but there seemed like there was a little more autonomy. They didn't have the same kind of restrictions that nursing still has (p. 19).

KI #5: ...maybe where I've heard it from our graduate students, nurses who are doing graduate work reflect on their undergrad experience and compare it to graduate education and say that in an undergraduate nursing environment, you're not really taught to think critically about what you're learning. You're taught to learn the rules and the content. I don't know how true that is but I guess I'm thinking that for ANS who often have more life experience which teaches you by definition to challenge things and think more critically about things but who also comes in from a different set of cultural values and thinking about connection between health and social life and those kinds of things – thinking about what health is and how to respond to people who are sick and caregiving values and all those kinds of things are quite different. I can see how that would create particular kinds of challenges (p. 11).

Along with the perceived conflict between critical thinking and conformance, several KIs provided further insight into another conflict that ANS might experience. Conflicts in values and belief systems were also acknowledged and labeled by KIs as cognitive dissonance.

7.3.2 Cognitive dissonance

Several KIs identified that some Aboriginal people, learning how to become a health care professional, may experience cognitive dissonance and struggle with internal conflicts. Some ANS might grapple with the new identity of being a member of the health care system and at the same time, being an Aboriginal person. Historically, KIs acknowledged that Aboriginal people were oppressed by the 'system' and questioned how ANS could subsequently become a member of this health care team. These KIs questioned how ANS could identify themselves as "insiders" or team members within a health care system known to fail Aboriginal peoples.

KI #5: I've talked to [Aboriginal health profession] students here for example, and they're training and listening to experiences they have in the emergency room and on the wards. There is a high proportion of Aboriginal people and the kind of ongoing discriminatory attitudes on the part of staff that becomes part of their training environment. The cognitive dissonance that they have to manage, in terms of being part of the team, being part of the health care team and at the same time recognizing the difficulties that their people are having coming to these environments (p. 6).

KI #11: We expect them to come through that process as strong professionals, who will graduate clinically strong, strong advocates of the system because after all, they should understand it better after being through the training and also strong advocates for Aboriginal people. And I think that all of those roles are conflicting to some sense. I think the very fact that the health status of Aboriginal people is so poor, in part says that the system as it exists has failed. If not the health system, then most of the determinants of their health probably rest outside of the health system but I think clearly, often the experience within the health system for them is less than ideal and we create these new educational products and now the finished product, the Aboriginal person that remains pretty conflicted because they understand how the system works, they understand where the Aboriginal people are coming from. It is very hard to reconcile those and fix it. I think often they feel trapped so it tends to force them into saying either they can't. "I am here to advocate and make things better, so that means I have got to work a little more outside the system than inside the system." And they set up their own peer structures with Aboriginal people that makes it then very hard for them to actually influence the system. Its ten steps back for them. So I think it's a huge dilemma (p. 2)... See a lot of them get into the program being reasonably skilled but all with a bit of anger that the system doesn't work. It is not changing fast enough. Those that they even remotely saw as mentors clearly must have failed because the system still is the way it is and what role do they then have? (p. 3)... I think that we have made them so uncomfortable that they just don't feel that they fit and of course, the real drama is that they don't fit in either culture. They don't fit in their own culture because you have given them an information base that they now use and have to use. And they don't fit in our culture because they are alienated. They sense the truth (p. 5).

KIs validated ANS' stories of struggling with limited primary and secondary education and their need to readjust to urban and campus lifestyles. Several KIs offered unique insights about conflicts that ANS may experience. KIs viewed that many ANS developed critical thinking skills to survive and cope with past life experiences. Several KIs viewed that schools of nursing were learning environments where questions about taken-for-granted practices were unwelcome. The other distinctive insight was that it would be likely that ANS experience cognitive dissonance and value conflicts by

adopting a new identity as a team member in a health care system that failed to promote health and prevent illness of Aboriginal peoples. I now proceed to present KIs' viewpoints about the translocal context where ANS learn how to become a nurse.

7.4 An uneven playing field

I present the trajectory of ANS' experiences in schools of nursing as seen through the eyes of the KIs. I include KIs' perspectives of entrance requirements, nursing faculty, student-teacher relationships, curriculum and pedagogy, clinical courses, class sizes and evaluative methods. From the standpoint of KIs, rigidity, Eurocentrism, power differentials, and racism within the translocal context created an uneven playing field for ANS. In regards to the translocal context, KIs proposed a strategy to support ANS. Some KIs acknowledged how the incorporation of a mentorship program could enhance the educational experiences of ANS.

7.4.1 Entrance requirements

Access programs were identified as important avenues to open the door for many Aboriginal peoples into postsecondary education including schools of nursing. KIs deemed access programs as necessary avenues to recruit Aboriginal peoples into nursing and make obtaining a nursing education a possibility.

KI #1: Many of our students and I think about 40 – 45% are single parents and of course, the overwhelming majority of those are single mothers. Given their situations and that they're single parents and they likely didn't finish high school, that [postsecondary education] is not something that they could even think about and if they did come, they would have no way of affording to come (p. 13).

KIs perceived that administrators and educators in schools of nursing highly valued GPAs. Some KIs expressed their concerns that nurse educators equated students with high GPAs as excellent clinicians. In KIs' experiences with other health professions, GPAs were not associated with ability to provide competence and caring in practice.

KI#1: If it's strictly based on academics and MCAT, some of our best graduates might not have gone through. Some of the students who have done the most in the [First Nations] communities might never have graduated, would never been let in because of these high academic requirements. So anyways, I think it's a bonus for that at the end they do have a stereotype associated with them and oftentimes I've heard it from our doctors that they're looked upon differently because they're an access student...And it's never been proven and we've looked hard at MCAT and academic entry level GPAs and MCAT scores do not determine how good of a doctor you will be in any way, shape or form. They determine how well you may do in your first year medical studies but they don't determine how well you'll do actually in a practice when you're dealing with patients and in some cases, I found the reverse is true. Our doctors, even though they don't come in with a high MCAT or high GPA, do well in practice situations. They're loved by their patients. They do right by their patients and are accepted etc. and the quality of care is better. I guess in the [postsecondary institution] I don't want to be too specific, but in the [postsecondary institution] we always look at grades as being the ultimate achievement here and you know in some [schools] it's just not true. That's not the people who are doing the best out there (pp. 7 – 9).

Several KIs identified that students who entered the school of nursing via the access programs were sometimes labeled by faculty as having an “easy” ride. This misconception created a disjuncture in that nurse educators were sometimes resentful about the perceived easier tenure, limited curriculum and lower expectations.

KI #6: Students from the Access program – there's a lot of misconceptions about it, like the fact that the [postsecondary] community including staff believe that if a student is an Access student that their degree is easier for them, less challenging. But that's not the reality (p. 23).

KIs identified the current trend to recruit more Aboriginal applicants into schools of nursing; they believed that Access programs were key to providing disadvantaged individuals with the opportunity to obtain a nursing education, pursue a nursing career and make a better life. Because KIs viewed that GPAs were not indicative of “good” practicing nurses, they were supportive of having alternative avenues for Aboriginal peoples to access nursing education. In the following section, I address KIs' interpretations of the nursing faculty.

7.4.2 Perceptions of nursing faculty

KIs viewed that educational administrators and faculty were supportive of the initiative to recruit Aboriginal peoples in nursing. However, KIs perceived that nursing faculty demonstrated ambivalence in the notion of retaining ANS. KIs perceived that some nurse educators and administrators were sustaining an uneven playing field by denying that ANS' experienced discrimination and racism in the schools of nursing.

Nursing faculty appeared to be entrenched in Eurocentric methods of teaching and learning and lacked the skills and resources to implement inclusive teaching strategies. Several nursing faculty members were described as being "closed" to the notion that strong Eurocentric models of teaching and learning were discriminatory towards Aboriginal peoples.

KI #1: ...I deal with [other administrators] over there and some other staff and they're all very receptive but they get very prickly when I suggest that there might be a problem in nursing – discriminatory things happening in nursing. They get very defensive and very upset and sometimes I wonder if there's a bit of a "head sticking in the sand" over in nursing so you don't see the problem and they just don't want to get into it. They just go back to tried and true phrases that people who have been discriminated against have used many times before. "You're not as good as everybody else. You can't do this." They hear those phrases all the time, so I wonder (p. 31-32).

KI #2: And I think the faculty might want to say there is no racism. To say that is blatantly silly because there's no way that the faculty can say, "We are a non-racist faculty." They don't know the individual feelings and attitudes of any given instructor. All of us could probably stand up and say we're not racist but I'm sure at some level (pp. 14-15)...

Donna: What factors would diminish the ability to recruit and retain Aboriginal people in nursing education?

KI #2: I think racism. I think they [ANS] would chalk up all these kinds of experiences that they had, these negative experiences to racism – lack of understanding of their life situation, the broader context in which they've been raised and have to survive and so I think on the part of faculty – lack of understanding and trying to treat everybody in this cookie-cutter approach will, the ones who really want to get through will do it in spite of it. But word of mouth then gets around...I think that is the biggest barrier and the faculty might not want to say they have racism but maybe they are thinking racism with a large 'R' and from the Aboriginal students' perspective, it would be a small 'r' – racism. If the faculty don't have anybody distributing anti-hate literature but that these types

of attitudes that people have are interpreted by Aboriginal students as being racist. That's the biggest issue (p. 19-20).

This KI voiced her concern that nursing faculty members were justifying that more complaints from student nurses were due to less qualified students being admitted into the school. This KI concluded that the faculty member was over-simplifying the higher number of student nurse complaints by blaming the students, not the system.

KI #6: I had a conversation with a [nurse educator] ...and had made a comment that – she was justifying. “Well, that’s going to happen. You’re going to get a number of [student rights] complaints [from nursing students], naturally – there’s so many more students that shouldn’t be in the program, so I don’t know what the big deal is about all these complaints.” Part of it is true. If you’re going to have more numbers – you’re going to have more complaints. I think that is simplifying (pp. 13-14).

Several KIs identified that nursing faculty required more openness to different worldviews and practices. KIs were perplexed about strategies to accomplish this openness and to develop inclusive teaching in schools of nursing. Although some KIs recommended that nursing faculty might benefit by taking cultural awareness workshops, KIs held differing viewpoints about the most effective strategy to promote inclusiveness.

KI #2: [Some ANS] felt that the people in the nursing faculty there really had racist noted attitudes and they had great difficulty bridging differences and there were a lot of misunderstandings (p. 5)...I know it’s important to try and offer culturally appropriate, culturally sensitive material. However, I think it’s very burdensome on nursing instructors as well because if you have no familiarity with the culture, it’s a very difficult thing to be able to try to do because most all instructors know is their own culture and I think that in general, there are certain guidelines in which you interact with most people (p.6)...I know that people have to do things like sort of cultural awareness programs if you’re going to be working in the First Nations community. There should be some attempt at least to maybe try and understand what the culture is. Even that is difficult because there’s kind of a feeling in those kinds of things that all Aboriginal people are the same and all Aboriginal people think different than we do. There is a tendency to place them in the other category without getting to know them as people first (p. 11)...I just see it as maybe there’s an opportunity for a lot of misunderstanding. I can’t help but think that if there was more of an understanding and if people were more willing to treat people on an individual basis that that couldn’t help but enhance recruitment and retention (p. 22).

From the perspective of KIs, some faculty members were unwilling to examine or explore the notion that ANS experienced racism, rigidity and Eurocentrism. Rather than explore others' suggestions that racism was perceived, nursing faculty members pronounced their moral obligation to ensure graduates attained entry-level professional standards.

7.4.3 Student-teacher relationships

KIs concluded that tensions and misunderstandings would most likely transpire in the student-teacher relationship. From the standpoint of KIs, ANS were treated as children and/or as less intelligent than Non-Aboriginal nursing students. Because of the history of Aboriginal education in Canada, many KIs perceived that the power differential between ANS and nurse educators was wider than between a Non-Aboriginal student and teacher. KIs acknowledged that the power differentials set up situations where ANS had two choices in a conflict. Firstly, students that conformed to the clinical teachers' wishes would be provided with a passable grade. Conversely, students that failed to conform would be punished with a failing grade.

KI #2: You start with a respectful attitude and perhaps some people are better at "Okay, we're in this relationship as an instructor and student" as kind of a partnership. Now there is a hierarchy. It doesn't matter. There's a power relationship there but to try and keep it on the same playing field anyway that there's things I have to impart to you. This is the type of knowledge that you need in order to be able to be competent in your job and that's what you want to do obviously (p. 8)...I just recalled an incident where a woman told me of a situation when she was doing her [nursing program] I think through [name of school] or she had been registered there first and she said that the faculty there treated the Aboriginal students like children and they didn't feel the same level of respect as was afforded the Non-Aboriginal students and she said to the point that she actually got her knuckles wrapped with a ruler one time when she was in clinical practice by the teacher and she whacked her on the hand and I thought this is old style grade school (p. 6)...Some people, from what some Aboriginal students have told me, the impression they have of the instructors is that the instructors think that the Aboriginal students may be less intelligent (p. 9)...It's risky and would take someone who has a very strong sense of self and an understanding of how the system works. There's not too many people at that

level of life that have that presence of mind. "Well, I'm not going to stop with you." There is that power relationship and they're frightened of what will happen to them (p. 23).

KIs acknowledged that ANS were positioned to experience a wider power differential when interacting with nursing instructors. ANS were required to conform to the teachers' wishes in order to continue in their nursing education program. In the following section, I present KIs' viewpoints about the nursing curriculum and pedagogy.

7.4.4 Curriculum and pedagogy

KIs viewed that the curriculum would benefit by the inclusion of more information about Aboriginal culture, health beliefs and practices. Nursing education was viewed as Eurocentric in terms of curriculum development and pedagogy.

KI #5: I think in general it's difficult sometimes, but sometimes for Aboriginal people in health professional education programs generally so I'm not sure I would single out nursing but I think nursing, medicine, dentistry, rehab – the various professions, I think the kind of professionalization, socialization process as well as the scientific paradigms are difficult for [Aboriginal peoples]... They are very Eurocentric. They can seem discriminatory. I think they can be perceived as discriminatory and that they value certain kinds of behavior and knowledge and devalue other kinds of behavior and knowledge and I think it is particularly for people who are strongly embedded in their culture worldview, it can be really a difficult process but I wouldn't say... When I say I haven't heard that perspective particularly from nursing students, it's only because I haven't talked to them or asked them. It's a sample of zero in a sense is what I'm saying. I'm not saying that it's because they have not said it. It's just that I haven't heard it (p. 2)... It's the bias that we don't have culture – only they have culture and our standards are somehow objective. These training regulations and guidelines and frameworks and standards are all objectively determined? They are independent of culture and their problems are culturally determined and yet our standards and guidelines that have all emerged out of experience and training young single unattached educationally motivated students for the most part. So those guidelines and standards are not detached from a cultural experience and they're not detached from an historical socialization cultural environment. Advancing that kind of understanding in people who are responsible for education and training in a multicultural environment is difficult. Because people are quick to say, "Well, there's something cultural about the problem the student is having," but they're not so quick to say there's something cultural about the program that we have developed that's causing problems for students from other cultures (pp. 8-9)... I guess I have heard that if you're comparing nursing education with other professional education that nursing education has a tendency to be more

paradigmatic – that it has less flexibility in terms of accommodating different interests and learning styles and that sort of thing (p. 10).

KIs believed that schools of nursing failed to include relevant information about Aboriginal health issues in its curriculum. In fact, the curriculum was seen as not meeting the needs of the current and future population base.

KI #7: [ANS] say sadly that there is only one [nurse educator] who actually addressed Aboriginal health issues in their curriculum. And they told us her name so I went to the [head of the school] after and said, "Give that lady a gold star." And the [head of the school] said, "I had no idea that she would be the only one and that she was doing that" so that was different (p. 19).

KI #11: I think they [nurse educators and administrators] develop their curriculum and training programs in remarkable isolation from what the service needs in the community are (p. 8)... Well, I think that throughout the prairie provinces I think that even to a small extent, Ontario and B.C. – the whole country, I think that this view of a little smattering of Aboriginal issues, a couple of lectures, is going to be enough to create a sensitivity and awareness and more importantly, an understanding of where these folks are coming from, what the limitations to their clinical capacities to the north are, to this day this has been around a long time, trying to talk about this stuff and I still walk into emergency rooms and hear a doctor or nurse complaining about a northern nurse dumping this patient, with no understanding that it's dark, it's cold, didn't feel comfortable with that (pp. 10-11).

KI #11: The Aboriginal community – it's not going to be just geriatrics in the next 20 years. It's going to be pediatrics and with the rate of diabetes and its complications, morbidity is going to be so huge anyways that we are never going to have a huge geriatric population at least not until the end of two more generations probably before they catch up (p. 8).

One KI identified that many postsecondary institutions failed to seek key stakeholders' input into the projected health care needs and future population demographics. Limited communication between stakeholders and postsecondary institutions prevented relevant revisions to the curriculum in health professional schools. Postsecondary institutions were viewed as "ivory towers" that functioned in isolation from the rest of society.

KI #11: To change the curriculum at a [postsecondary institution] with all of the vested interests involved, with departments, with faculties, and individual professors and all of their autonomy being respected – changing the curriculum is a big item. They do it all the time in ten year cycles. What the feedback group

that helps them determine what they are changing to, eight years no one from the [postsecondary institution] has come to [us] and said, "What do you think the health care needs are going to be two decades from now?" (p. 9).

Several KIs voiced their concern that expertise in Aboriginal health was not highly valued by the nursing profession. Other areas of nursing were viewed as being more popular and more of a focus in the nursing curriculum and practice areas.

KI #10: There is the nursing profession, when you go out to work in public health for example, to work in sexually transmitted diseases if you have a lot of expertise in that area then you are valued for what you bring, but if you are working in a community area where Aboriginal health issues are paramount and you come in as an Aboriginal health expert with a nursing degree – that expertise is not valued in the same way that expertise in communicable diseases. Part of that is the trend you know public health, population health is not necessarily seen as much of a priority as emergency medicine or all of these other fields but at the same time... It's an area of expertise that really does need to be recognized (pp. 23-24).

Although KIs wished that information about Aboriginal beliefs, health, and traditional healing methods would be integrated into the nursing curriculum, KIs identified that it was important to present current Aboriginal health issues within their historical and sociopolitical context. KIs acknowledged that a clinical practicum in a First Nations community might offer students a broader experience in that they would be exposed to both the negative and positive aspects of Aboriginal health and acquire a broader knowledge base about the social determinants of health.

KI #10: One of the things that we talked about is how to ensure that there is some mandatory courses on Native Studies for other health care professionals. And there is a variety of approaches that have been tried. One of the things that we felt a few years ago to be important was to have students attend the Sweat Lodge and have some of the teachings there. I have never been quite sure how I feel about that. I mean Traditional spirituality to me is on the parallel with other spiritual classes such as Christianity, the Catholic Church, the Anglican Church, Jewish Synagogues, Hindu practices, and I am thinking that when we are learning about cultural differences among these Eastern groups – do we then go into a Hindu spiritual service or a Sikh service? Does that add anything? Is that sort of implying that this is what Sikhs or Hindus or Chinese or Jewish people are all about is their spiritual base. And how about the very important piece of it there are many things that have impacted, that have come together to create an impact on the health status of Aboriginal people. So I think that you need to look

at the historical influences, some of the cultural influences, and one of the things that you need to understand is that there is no such thing as a Pan-Aboriginal person...and if you go to a Sweat Lodge you are not going to be any more prepared for working with Aboriginal people than you were yesterday before you went to the Sweat Lodge. You have a different perspective on spirituality which will be a positive thing hopefully but it is not going to help you very much in your working with Aboriginal people who have some very real health issues. You do need to understand that there are so many social determinants of health that has more of an impact on health of this person than whether or not they are a true spiritual being whether that be a Christian spiritualist or a Traditional spiritualist...I never was comfortable with that focus in our curriculum and I think that we need to do a better job of teaching Canadians and other Aboriginal people as well as to why some of these things have had an impact on the way that we see things...(pp. 26-28).

From the standpoint of KIs, the nursing curriculum was based about the health care needs and practices of Euro-Canadians. KIs had specific impressions about clinical courses in nursing education. These ideas are presented in the following section.

7.4.4.1 Clinical courses

KIs' perspectives of ANS' clinical experiences involved the notion that clinical teachers and staff nurses practiced a Eurocentric model of nursing and teaching. KIs noted that alternate ways to practice nursing were unacceptable in the education system leaving ANS in a position whereby they were forced to conform.

KI #1: That in order to be a nurse, get [your registration], you have to pass a practicum and a clinical, two clinical evaluations and in those you're in the hospitals working with registered nurses who are trained, some maybe 5 years ago, 2 years ago, 25 years ago and that...their method of nursing is a European based ethnocentric, primarily Anglo-Saxon model in that no other idea of nursing fits into that. So when you're talking about why some [Aboriginal] nurses don't have any of their own culture when they graduate because they wouldn't have graduated if they would have brought that forward at any time in their nursing [education]. The only way that they could preserve that is by hiding it while they were going to school and even when they started they would probably be fired immediately if they tried something like that, you know hiding it for 5, 6, or 10 years until they were established nurses with some degree of experience and then bringing that forward in a climate that was conducive. Overall, you're talking about someone who has spent 15 years nursing one way and then trying to bring their culture back into it, it's a very difficult process (pp. 9 – 10).

KI #2: I think...that nursing is very rigid and rule based and you have to follow those things exactly and if you wander there's not a lot of room for creative thinking – I found that in nursing (p. 6).

Different ways of knowing and practicing nursing were unwelcome in schools of nursing. According to KIs, faculty members appeared to shun alternative epistemology and practice. This viewpoint resonated with the participating Aboriginal nurses' perspectives.

KI #5: I guess I have heard that if you're comparing nursing education with other professional education that nursing education has a tendency to be more paradigmatic – that it has less flexibility in terms of accommodating different interests and learning styles and that sort of thing (p. 10).

Several KIs identified that nursing instructors and staff needed to broaden their perspectives of safe and competent practice. By adopting an inflexible military approach to ensuring that students learn how to accomplish nursing goals in a specific way and time frame, KIs acknowledged that critical and creative thinking and assertiveness on the part of students would be unwelcome.

KI #2: I think nursing still has to undergo some really significant changes before – this whole idea of just being so inflexible and rigid and stick to the rules. Being on the ward and you have to get things done at a certain time or a certain way but to have that kind of army regimentation still on the clinical practice area in the learning experience – I think that's so outdated. A bygone era...All it does is reinforce 'task nursing.' Okay, we have to get this done and that done and do such and such but I don't think it helps people spread their wings and be professional (pp. 23-24).

One KI acknowledged that in the past, clinical teachers were provided with a session on cultural awareness. This session was developed following culturally diverse students' concerns about inflexibility on the part of clinical teachers.

KI #6: I know last year or two years ago there were a number of students who were concerned...There was concerns raised about what they were hearing from students and one of the things that came out of that and also at that time had involved [someone in the Access program] and what came out of that was a session for [clinical teachers] on cultural awareness and I know that took place. But I think that was the only thing that came out of out that was really concrete...They should get a week (p. 15).

KIs perceived that clinical courses were conducted in a rigid format with minimal openness to others' viewpoints or ideas about accomplishing nursing practice in a different manner. I proceed to present KIs' viewpoints about the evaluative process that occurred within clinical courses.

7.4.4.1.1 One-sided "snap shot" clinical evaluations

Several KIs identified that clinical teachers, by virtue of the student to teacher ratios and their role of evaluating students' performance, relied on 'snap shot' versions of students' observed behavior rather than gathering information about the entire context. Lack of communication between clinical teachers and ANS resulted in misinterpretations based upon "snap shot" versions of students' performances or lack thereof. Clinical teachers needed more information to explore the entire context shaping students' performances.

KI #6: It's almost like their [clinical teacher] or buddy nurse will do a quick walk-by to have a snap shot of what happens and then write something negative about it rather than asking the student. Asking more questions, but rather just interpret what was happening there – was that the student chose to stand and make the patient feel comfortable? There was no insight and the student will read that later and it'll be brought up later and they'll say, "No, that's not what happened. He invited me and I sat down. When did you walk by?" Or "I don't remember you being in there." So, it's a feeling that students are being observed but only a small segment of the overall picture is being evaluated and you don't feel that's fair (p. 6).

When students displayed either critical or creative thinking or shared different thoughts about clinical practice, clinical teachers became skeptical about students' conformity to become a task-oriented nurse. Clinical teachers were then more apt to observe the particular student's practice more often and more critically. With 'snap shot' observations and assumptions about behavior, clinical teachers gathered evidence that signified that the student was performing in an unsatisfactory manner. Clinical teachers formulated a contract called a performance improvement plan (PIP) to communicate

their concerns about the student's knowledge base and/or clinical practice. A PIP was a signal to the student to acknowledge responsibility for the error and conform to the teacher's specifications. If these two responses were not elicited, the student was destined for a poor or failing grade.

KI#6: Well, [nursing faculty] they'll explain that it's in place to help the student successfully complete the clinical but it's presented in a way that the student feels that they're being punished, that they're not doing something, it's likely that they're probably going to fail and I think maybe there is a good rationale to put a PIP in place but the way it's implemented and the way that students are presented with PIP and students feel that it's a horrible thing to have one. They don't see it as positive and I've been in meetings where they said, "I don't know why I had to get a PIP." And someone from administration will say, "The PIP is there to help you. We're trying to identify to you what the expectations were to help you meet them and this is the plan that's in place to make sure you meet those expectations before the end of clinical because if you don't meet them." But the way that it's normally done and I've heard this a few times, is a student will be told by a [clinical teacher] we're meeting at 2:00 and it's going to be the course leader and the students say and they'll be told, "Oh, we're going to go over your evaluation." So they'll sit down and that's when the PIP is presented. So the student will get their PIP for the first time and they'll have the student read it and sign it right there. The [clinical teacher] and course leader would have had time to talk about it. They would create it together. They may have even consulted the [administrators] at the [school of nursing] and they want the student to read it, respond, sign it and "Okay, now I know this and I'm going to go out and do a better job." Students are like – "I didn't do this." And they start arguing and refuse to sign it. Sometimes the students won't do that and it won't turn out the way they wanted or the student will sign it and they realize what the consequences are going to be so they feel that they don't really know what the consequences are going to be and then they find themselves debarred or getting a grade... (pp. 9-10).

Some KIs identified that student nurses from visible minorities, were sometimes apt to utilize their student rights and appeal clinical evaluations from nurse educators. KIs acknowledged that these student nurses voiced their concerns of being discriminated against by teachers. Although ANS utilized their personal agency to appeal a poor clinical grade, KIs identified that inevitably, the teachers' positions were upheld and the student would be required to repeat the course or withdraw from the school of nursing.

KI #6: ...the majority of them that do come with clinical concerns are non-Caucasians so they are international students or they're students who are a visible minority or are – English isn't their first language and usually what we've seen lately has been concerns because they're in a situation where they're being removed from a clinical ward because of their performance and the students feel they've been evaluated unfairly and that there's other reasons for why that decision was made. Students have used the words, discriminated, feel discriminated against (p. 3).

KIs identified that performance appraisals in clinical practice were subjective and based upon quick observations of students' performances within minimal knowledge about the entire context. KIs suggested that more communication between clinical teachers and students was warranted to gather needed information about the entire clinical situation. Although KIs understood that PIPs were sometimes warranted in situations where patient safety was breached, KIs identified that PIPs needed to be co-constructed in order to be perceived as less punitive and more helpful to students. More one to one communication between clinical teacher and student was recommended. Another strong recommendation that came forward from KIs was development and support for informal and formal mentorship programs for ANS.

7.4.5 No mentorship programs

Several KIs shared their ideas about a necessary strategy to support ANS – the establishment of informal and formal mentorship programs. By developing, implementing and supporting informal and formal mentorship programs, ANS would be more apt to acquire much needed support. Mentors were identified as other ANS, more experienced ANS or Aboriginal nurses. KIs perceived that ANS needed skilled and experienced support when struggling with issues such as relocation adjustment and/or racism.

KI #11: Until you can provide them mentors that can help them temper some of their fears and anxieties and angers it's very, based on where they come from, all come to the surface pretty quickly. See a lot of them get into the program being reasonably skilled, but all with a bit of anger that the system still doesn't work. It

is not changing fast enough. Those that they even remotely saw as mentors clearly must have failed because the system still is the way it is and what role do they then have? (pp. 2-3)...How do we get them together? How do we give them supports? How do we let them find some mentors? How do we give them access to the positive features of every program, so that they get a little more strength out of it? We don't do any of that stuff. We do some things well in [this province] that we can share with [another province] and [another province] I am sure does some things well through their house of learning that could be shared with other places. You know, why aren't we creating a bit of a consortium to support this part of our community more effective ways. Why aren't we getting [an Aboriginal leader] to come and other leaders so that they feel that there is a hope and a future and that they are representing something positive?

Donna: Yes.

KI #11: We just keep plodding away, each nursing school is kind of doing what they think is the right thing to do and very little connection (p. 14).

Although personnel in the access programs were identified as key mentors for ANS, several KIs voiced their concern that access programs were limited in that access programs lacked important financial, human, and physical resources. Because of a lack of government funding, human resources were particularly lacking as experienced by some ANS.

In summary, KIs identified factors within the translocal context that shaped ANS' experiences in schools of nursing. KIs identified that administrators and educators were supportive of the impetus to recruit more Aboriginal peoples into nursing education. On the other hand, KIs perceived that schools of nursing lacked resources to support ANS when ANS became enrolled in the school.

With a focus on ensuring safe and competent practice on the part of student nurses, nurse educators and administrators demonstrated their inclination to explore any avenues other than racism. KIs identified that the power differential between teacher and student widened when the student was visibly identified as Aboriginal.

Nursing curriculum and pedagogy were perceived as entrenched in a positivist or scientific paradigm that lacked information on Aboriginal health. In terms of pedagogy, schools of nursing were viewed as institutions that focused on the masses, not the

individual students. KIs acknowledged that clinical courses provided ANS with the most difficulties in that most clinical teachers were perceived to follow rigid rules and regulations with a focus on their role as performance appraisers rather than the role of teaching. From the experiences of KIs, students' evaluations were based upon one-sided "snap shot" versions whereby clinical teachers briefly observed students' actions or inactions and made certain assumptions. The process of conducting PIPs and clinical evaluations appeared punitive rather than helpful.

When KIs contemplated the translocal context, they identified a strategy to further support ANS. Informal and formal mentorship programs were described as necessary resources to provide ANS with needed social and professional support. KIs identified that nurse educators may benefit from more cultural awareness workshops. I proceed to share KIs' perspectives of extra local factors that shaped ANS' experiences.

7.5 External factors

From the standpoint of KIs, three main factors outside of the schools of nursing shaped the experiences of ANS. These factors were identified as:

1. Demands from home communities,
2. Health services based upon population needs? and
3. How society defines Aboriginal peoples.

7.5.1 Demands from home communities

KIs viewed that ANS experienced unique "pressures" in their student life based on additional responsibilities to their families, their Band, and their peoples. Firstly, I present KIs' interpretations of ANS' experiences of being "pulled toward" families.

7.5.1.1 Pull towards families

The 'pull' towards families refers to ANS' responsibilities and associated guilt in regards to attending to the needs of immediate and/or extended families in students' home communities. KIs identified that ANS highly valued their responsibilities to nurture and assist members of their extended families. ANS' responsibilities to extended families would often outweigh their academic responsibilities. Extended family members, visiting the city, were known to stay with ANS.

KI #2: One of the things students talked about was the pull. Students who came from reserve communities, that in some communities with some families there was support. There was an understanding that somebody could make something of themselves and we're so proud of her but when she left the community there were these pulls – you know feelings of guilt. "You don't come home enough" or "There's so much that happens in communities."... There's such a strong pull to the community that there is an expectation for that student. "You will come home and then maybe you will stay." And so they talked about those kinds of things where sometimes they actually quit school because the demands were so great and the demands of the community – it was real hard go for them. (pp. 17-18).

KI #1: We have students who are living; obviously they have to live in the city to go to school. This allows their relatives from another community pretty much extended family, when they come to the city they think they have a place to stay with the student and never mind that the student has to study or anything else but when extended family comes there's that tradition where "I have to take care of them. I have to focus on the family. My great aunt is coming. She's going to stay with me. I've got to cook her supper." All of a sudden, the student's not coming to school because their family's coming and visiting. All of a sudden, it's "Why aren't you succeeding? I only visited you once." Well, if everybody in the family visited once that's the whole year shot and that happens quite a lot and it's a situation – how do you deal with it?... And it's even sort of worse in a way that a lot of these people are coming here for medical reasons even, so you have an aunt who's coming to see the doctor, getting some treatments, you're going to kick her out of the house? (pp. 20-21).

KIs identified that Aboriginal students in postsecondary institutions might feel guilty if unable to return to home communities for special events, celebrations, and/or funerals. In addition to being responsible to immediate and extended families, ANS were known to also be responsible to the Band.

7.5.1.2 Responsibilities to the Band

KIs acknowledged that competition for Band sponsorship was steep while funds available were limited. In contrast to this sample of ANS where all students who self-identified as First Nations received Band funding, several KIs were aware that less than 50% of Status or Treaty Indians receive Band sponsorship to support postsecondary education.

KI #1: In general, there is far less funding for students who want to go to [postsecondary education]. So the Band might have the ability to fund 20 students to come to [postsecondary institution], but my have 45 students who want to go. The Band prioritizes, obviously they have to. In general, every Band has their own rules, but in general what I've seen is students who have come sequentially out of high school have the best chance of getting funding because it's believed they have the best chance to succeed. Students who are aligned or Band residents who live on a First Nations community have a much better chance of getting funding... We've sort of rolled out two groups of people – those are single mothers because they have children and again the other part is single students with no children have a better chance at getting funding and just for reason that with limited funding dollars, they could send one student who has a child to [a postsecondary institution] or they could send two students. Again these aren't hard and fast rules. These are just very general rules because every Band is different and I have seen single mothers get funding from their Bands but in [this province] and especially [this city], we're talking about 3rd and 4th generation urban Aboriginal people so they're still First Nations people. They're still associated with a Band but it was their great grandmothers who left the Band. In general, these people have very little chance of getting funding from the Band. The Band knows them as a name on the Band rolls but has no idea who they are as people. They're not visible in the community and when they have a choice to fund this person who I know is my friend's son and this person who I don't know who went to school in [the city] and I don't even know her parents – well, where's the choice going to be made? That's generally how it goes. We find among the First Nations People that probably less than half of them get funding from their Band (pp. 16-17).

When ANS received Band sponsorships, KIs acknowledged that the Band would ascertain certain expectations from ANS. KIs identified that ANS would likely feel pressured to maintain certain academic standards.

KI #1: In the situation of many of our students – they are the first ones in their communities to come to [a postsecondary institution] to do any [postsecondary education] and a lot of riding on them with their families, with the Band who are expecting a certain degree of success from them. Sometimes the Band doesn't

understand when they come here the first year and they struggle because it is very different from the high schools they went to. They come here and struggle and we find many of our students get down on themselves for various reasons because they're struggling and their Bands are expecting them to get As and they're not (pp. 18-19).

KIs identified that government provided additional funding to Aboriginal students in Access programs by subsidizing their income in the form of bursaries. One KI acknowledged that only 25% of Aboriginal students acquire bursaries through Access programs.

KI #1: ...so fewer than 1 in 4 actually get a bursary. The rest find funding in different ways...And the other students do it entirely on Canada Student Loans and some students find funding in various ways. I think that's the piece I wanted to say is that not all of our students are "free" from their Bands in that sense (p. 18).

KIs identified that ANS were responsible to immediate and extended family members as well as home communities. If ANS successfully acquired Band sponsorship, they would aspire to maintain a certain academic standard and course load despite their struggles. In addition to these aspects occurring outside of the school, KIs voiced their perspectives of ANS' experiences returning to work in First Nations communities.

7.5.1.3 Returning to Aboriginal communities

KIs identified that many ANS would return to Aboriginal communities to work. Acquisition of a nursing education was often motivated by a desire to help Aboriginal peoples.

KI #8: A lot of the Aboriginal people that I know who have gone back for postsecondary education was because they were inspired to help their community.

Donna: Yes.

KI #8: This is a huge thing. Some people say, "I want to make big bucks." And that is true when you are young – you want to make big bucks. But there are a lot of people who go into it because they know, they have an idea like, "I could go back to my community and I could do this"...

KI #9: That is what I was going to say is a big one, too. I find that our people that a lot of them went back to school later in life. They have got children at home and they want to teach them that you know, they weren't taught that. That is why there is a lot of difficulty too. They have never seen anyone go through [postsecondary education] (pp. 26-27).

Validating some ANS' concerns, KIs identified that Aboriginal peoples were sometimes viewed differently by their home communities. Acquisition of a postsecondary education somehow transformed the Aboriginal individual into an 'outsider' so returning to a First Nations community to work was challenging.

KI #1: Many of our graduates, when they graduate with whatever degree and they attempt to go back to their communities are viewed differently. They're viewed as – when they have an education they don't fit in with their old friends. They don't fit in their old communities. In reality when a student comes here to be educated from their community, generally you can almost safely say they're not going back to their community because there's just that much – it's just difficult to go back. We've had many who have gone back and then spent a year, 6 months, 3 months and then left again. Even though they were raised there all their life. It gets more difficult when you talk about the higher the degree, right? (pp. 22-23).

Although ANS were known to be highly responsible to their immediate and extended families and Bands, being educated in a postsecondary institution caused ANS to be viewed differently by members of their home communities. ANS would experience a conundrum as they were "outsiders" in their communities and "outsiders" in the health care system. The next feature in the extra local context addressed by the KIs was the need to develop health care services based upon population needs.

7.5.2 Nursing education and population health

With the rise in the Aboriginal population and a future trend towards a young Aboriginal population, KIs acknowledged the need for more Aboriginal nurses with the addition of nurses who were more culturally aware and culturally sensitive. KIs voiced their concerns that service providers needed to work more diligently with schools of nursing to recruit more Aboriginal peoples as Aboriginal nurses were urgently needed.

KI #5: The connection between need and resources still isn't even close to where it should be. Given population demographics and trends and changes, the proportion of Aboriginal students in various programs should be much higher than it is and the funding support for students... (p. 17).

KI #12: There are a significant absence of Aboriginal faces as I walk through [the hospital], from an employee perspective. So we very much need to increase our potential. The commitment there, we need to operationalize that commitment and to really begin to figure out how we support the education system in attracting Aboriginal students because we can't of our own, hire Aboriginal professionals. They need to come to us from somewhere...We don't do well hiring Aboriginals (p. 1-2).

In terms of Aboriginal health, KIs identified that Aboriginal health issues and services were becoming more visible in the health care community. With the increase in the Aboriginal population and the need for more culturally sensitive health services, special services for Aboriginal peoples were now seen as warranted.

KI # 7: Recently, they have moved their Aboriginal services office, for instance, to a much more visible location within the hospital. It used to be kind of tucked away in a far corner. So they are trying to be very visible about it (p. 5).

As Aboriginal health issues were becoming more visible to society as a whole, addressing Aboriginal health issues were in the forefront of various health agencies' mandates. Having more Aboriginal nurses in Aboriginal communities working on health promotion and illness prevention was viewed as imperative, while more Aboriginal nurses in a biomedical system was seen as less significant. The final aspect within the extra local context was how government and society view Aboriginal peoples.

7.5.3 Portrayal of Aboriginal Peoples

KIs acknowledged that society's viewpoints about Aboriginal peoples influenced how ANS experience their nursing education. Firstly, KIs identified the implications of how government defines Aboriginal peoples. Secondly, KIs identified the implications of how the Canadian media portrays Aboriginal peoples.

7.5.3.1 Government

KIs acknowledged the historical features of treaty rights and the importance of identity in shaping how federal and provincial governments identify who may be eligible for Band sponsorship. Status or Treaty Indians and Inuit peoples were identified as the only peoples eligible for Band sponsorship or funding from the federal government for postsecondary education. Non-status Indians and Métis peoples were ineligible for Band sponsorship or federal funding; thus, they had limited resources available to support acquisition of postsecondary education.

KI #1: So only people with Status are eligible to get educational funding from their Band.

Donna: Okay.

KI #1: These are Status Aboriginals. They can trace their heritage back to a signer of one of the Treaties. That heritage isn't lost and they are recognized by the federal government as being a Status Indian and they are the only ones who can go to their Band for funding. Métis people really have much more limited resources and so do Non-status Indians (p. 15)...If your mother was Aboriginal you can get your Status, your C138. If your grandmother was Aboriginal you can get your Status. But if your great-grandmother was Aboriginal then you're not Status Indian – you would be a Métis person or Non-status (p. 16).

KI #5: There are several issues, one is the inequities around Status and the fact that certain Aboriginal students by virtue of being Status, registered First Nations have access to resources that Non-Status or Non-Métis and other groups don't have and whether or not the province has made that environment more equitable or not – I think that is one question (p. 17).

Several KIs identified the inequities around how governments define Aboriginal peoples. KIs were aware that individuals labeled as Non-Status or Métis lacked the availability of many resources that Status Indians or Inuit peoples received.

7.5.3.2 Canadian media

The negative portrayal of Aboriginal peoples within the Canadian media was addressed by several KIs. Because positive images of Aboriginal peoples were limited, KIs voiced their concerns that Aboriginal peoples would have difficulty achieving equality within schools of nursing, workplaces, and Canadian society.

KI #8: People have bias that they don't even realize and it's not intentional. It's not what I would consider mistreatment but you know, we are bombarded with the media you know, showing Aboriginal people killing other Aboriginal people in the streets on almost a weekly basis. You know we watch Cops or whatever the Canadian version of it. You know those are Aboriginal people getting arrested the majority of the time. You know we look at you know, all the businesses or organizations that are operated by Aboriginal people and most of them are social service or addiction kinds of facilities or job-search facilities you know over time getting bombarded with all of those visions and the negative editorials in the [city newspaper] about the Aboriginal community, about urban reserves, and the misconceptions about what that actually means you know. I don't really blame people for having that but just recognizing it and knowing that okay, we live in [this city], we live in Canada (p. 25).

KI #11: I think innate racism exists in society as a whole, therefore they see it from patients, they see it from staff, they see the stereotyping you know with other staff imposed on Aboriginal patients based on the experience that staff has had and somehow we expect them to come through the process as strong professionals, who will graduate clinically strong (p. 2).

Only one KI voiced a concern that many Canadians failed to recognize how land deals through treaty negotiations created many resources and opportunities for Canadian people. This KI addressed the impropriety of any Canadians feeling resentful about treaty rights.

KI #5: It's easy to perceive the advantages and benefits of someone else without understanding all the responsibilities and demands on time and resources etc. and there are historical treaty related rights and privileges that some people have that other people don't and they deserve those because there was a huge land deal that is still being paid for basically. Those are the kinds of things people – there shouldn't be any resentments around those things. The advantages that we have as Canadians are built on those initial deals (p. 18).

7.6 Chapter summary

In this chapter, I presented the empirical findings from the standpoint of 16 individuals identified as being knowledgeable about the broader social context shaping ANS' experiences. Guided by tenets in the theoretical and methodological perspectives, I began the chapter with KIs' insights into the historical context of recruitment and retention of Aboriginal peoples in schools of nursing.

In terms of the local context, KIs validated two main concerns voiced by ANS: (1) how primary and secondary education on reserves ill-prepared students for postsecondary education, and (2) culture shock associated with relocation adjustment to cities and large campuses. KIs concluded that many ANS were mature, single parents who developed critical thinking skills to survive and cope with life circumstances. ANS would likely experience value conflicts between the Aboriginal worldview and the worldview presented in nursing education.

Although KIs acknowledged the importance of access programs as an entry point, human, physical, and financial resources were not available to retain and support ANS. Several KIs had experiences with nursing faculty that built an impression that nurse educators and administrators denied that ANS would interpret rules, regulations, and teaching practices as discriminatory. Failure to explore and examine ANS' claims sustained hegemony as nurse educators were focused on upholding professional standards.

KIs identified that power differentials widened between student and teacher when students were visibly Aboriginal. Nursing curriculum was based solely on Euro-Canadian health beliefs and needs. Nursing pedagogy was described as rigid and punitive in nature. KIs recommended two important factors within the translocal context: (1) development of informal and formal mentorship programs, and (2) more communication from instructor to student with a focus on teaching rather than performance appraisals.

I identified three themes that emulated KIs' perspectives about 'outside' factors that influenced ANS' experiences. These extra local factors were the ANS' responsibilities to home communities, health services based upon population needs, and how Aboriginal peoples were portrayed in Canadian society.

8 HOW NURSING DISCOURSE SHAPED ABORIGINAL NURSING STUDENTS' EXPERIENCES

The ruling relations are text-mediated and text-based systems of 'communication,' 'knowledge,' 'information,' 'regulation,' 'control,' and the like (Smith, 1999, p. 77).

8.1 Introduction

In this chapter, I present the empirical findings related to nursing discourse and its influence on the construction of ANS' experiences. Relying on the theoretical and methodological perspectives of D. Smith (1986, 1987, 1999), I reviewed a variety of texts (identified earlier in the research as pertinent to ANS' experiences) to decipher how nursing discourse shaped ANS' experiences. Because the social organization of knowledge provided me with a theorized basis for critically examining textually mediated discourses, I reviewed brochures, course syllabi, textbooks, policies, procedures, and websites to explore how ideas and social forms of consciousness might originate outside of ANS' experiences.

I begin the chapter with a brief description of various texts reviewed. I proceed to identify the disjuncture between the texts and the actuality of ANS' everyday experiences. I link discourse analysis to pertinent findings explicating why these findings surfaced.

8.2 Overview of reviewed texts

To review nursing discourse, I collected participating schools' recruitment brochures, websites, policies and procedures related to student support services, equity, inclusiveness, and anti-racism. I randomly purchased course syllabi and textbooks representing at least one course from the various years of study at both research sites (See Table 3 on page 256).

Table 3**Profile of Texts Reviewed**

Description	Number Reviewed	Analysis
Recruitment brochures (Schools of nursing)	2	No specific reference to recruitment of Aboriginal peoples
Information brochures – Access Programs	2	Specific reference to recruitment of Aboriginal peoples
Course syllabi	14	No learning objectives/outcomes related to Aboriginal health
Required Readings/Articles	79 articles + 20 websites	7 journal articles and 1 website offering information on Aboriginal health (8%)
Required textbooks	5	1 mention of an Aboriginal health institute; 3 pages on cultural competence
Schools, postsecondary institutions' websites; Professional nursing association websites	10	2 sites address cultural diversity in population base; Policies/procedures about discrimination under harassment
Student handbooks - School policies & procedures (also available online)	2	Identifies Aboriginal student resource centers and other resources
Canadian RN Exam Prep Guide	1	Uses measures to evaluate cultural awareness, sensitivity, and respect without stereotypes
TOTAL = 135 texts		

8.2.1 Recruitment brochures

Specific mention about recruitment of Aboriginal peoples was absent from the research sites' recruitment brochures. Descriptions of nursing education programs identified that students would learn how to nurse individuals, families, and communities in a culturally diverse population base. The growing Aboriginal population was not identified. In regards to course descriptions, specific reference was made to elective courses in Native Studies about Aboriginal peoples in Canada.

In contrast to these recruitment brochures directed to "mainstream" nursing applicants, informational brochures about Access Programs from both postsecondary institutions clearly stated that preference was given to Aboriginal peoples, new immigrants, and individuals from a lower socioeconomic status. As many ANS in this sample relocated from northern communities and entered their nursing education via Access Programs, the content and design in the Access Programs' brochures targeted the appropriate group.

8.2.2 Course syllabi

Of the 14 course syllabi reviewed, I was unable to locate any learning outcomes that specifically identified development of awareness and ability to provide culturally appropriate care to Aboriginal peoples in theoretical, laboratory practice sessions, or clinical courses. This finding was similar to survey results in a study exploring Aboriginal health in the curricula of Canadian medical schools (Redwood-Campbell, MacDonald, & Moore, 1999).

How did I interpret this finding in the discourse? One might interpret that leaders in medical and nursing education continue to follow visions and missions of their

predecessors, without acknowledging the changing demographics and the changing context in health care. One might interpret that leaders in medical and nursing education value academic freedom and therefore, rely upon course instructors to shape the curriculum content with minimal direction from administrators.

Using these assumptions, I questioned how nursing faculty members choose curriculum content and instructional design. In that most of the 24 nursing faculty members were relatively experienced in nursing education yet expressed inexperience at teaching ANS, I reflected back on my own experience developing course content and instructional design. Often, I relied upon previous educators' syllabi as a template and proceeded to introduce content and teaching strategies that I judged as pertinent based upon my previous clinical and teaching experiences. Although I was privileged to have a graduate course in curriculum development, I rarely developed course syllabi in collaboration with other faculty members, previous students, and upcoming students. Based upon the transcripts from the 24 nursing faculty members and my own experience as a nurse educator, course syllabi were often developed in complete isolation of the contextual trends in health care and education.

Information about Aboriginal health was limited in that I located three syllabi in which nurse educators identified that aspects about Aboriginal health were included in that particular course in the format of lectures or presentations from Aboriginal Elders. In these instances, Aboriginal health was addressed in one lecture out of 21 time slots under topics related to promotion of health of individuals, families, and aggregates from diverse cultures. I questioned how students would interpret the meaning of "diverse"

cultures. I interpreted that the presentation of this material reflected that "diverse" meant "different."

Both schools of nursing identified a multicultural population base. In four of the 14 syllabi, I located the word, "culture." For example, "selects methods of communication which are appropriate to client circumstances, e.g. culture, age, needs" and "applies concepts and principles of effective communication specifically related to cross-cultural communication." In comparison with findings in an institutional ethnography conducted by Paterson, Gregory and Osborne (2004), culture variations or cultural differences in nursing education were presented as "other" with the dominant Euro-Canadian culture not identified as a cultural group of privilege.

Jillings and O'Flynn-Magee (2006) identified a synthesis of phases in the process of curriculum development and instructional design with a foundational phase on contextual elements. Nurse educators and administrators were encouraged to gather data and determine the actual and potential implications of a number of factors on nursing education such as health care trends, teaching and learning trends, sociopolitical influences, the institution's mission and resources, standards of practice and stakeholders' needs. To foster student-centered teaching, curriculum was viewed as praxis (Jillings & O'Flynn-Magee, 2006). My analysis of the discourse reflected that the contextual element of health care trends in the Aboriginal population were addressed only by providing nursing students with one or two courses in Native Studies. Therefore, I concluded that development of nursing curriculum was limited in its identification of the growing Aboriginal population, the health care needs of the Aboriginal population, and the Aboriginal community as key stakeholders.

Contrary to interpretations of several KIs, 50% of the course syllabi included learning objectives about students' development of critical and/or creative thinking skills. Learning objectives for clinical courses were based upon students' achievements of application of the nursing process in clinical and community settings in a safe and competent manner. I questioned how Non-Aboriginal laypeople and ANS would comprehend the language emulating from the culture of nursing such as the nursing process, safety, and competence.

Although nurse educators expressed a moral responsibility to protect the public from harm and relied upon nursing practice standards, only three syllabi from theoretical and laboratory practice referred to professional nursing practice standards and the *Code of Ethics* developed by the Canadian Nurses Association. Within the nurse educators' overviews of these courses, they stated, "this course will assist the student nurse to achieve the expectations set by" entry-level competencies of the provincial nursing association. In these syllabi, I noted that students were presented with clearer descriptions as to what was expected of them upon completion of the course and as beginning practitioners. To foster a more transparent and clearer description of clinical expectations, nursing students might benefit by having the specific practice standard in their course syllabus.

In contrast to the clear and understandable learning objectives from three courses, I was unable to decipher a clear meaning about the evaluative criteria for one clinical course. In this syllabus, students were provided with definitions of qualifiers ranging from outstanding to unsatisfactory. From the standpoint of a newcomer to nursing jargon, it would be difficult to translate these qualifiers into tangible expectations

of practice behavior. For example, satisfactory performance was equated with a grade level of C and meant that the student performed nursing care at a level satisfactory for a nursing student. A satisfactory student was described as capable of identifying theoretical principles but required assistance applying principles to practice. Provisional performance was correlated with a grade level of D. A provisional student was described as performing nursing care at a level below that expected of a nursing student and identifying fragments of principles that were applied inappropriately. This student's care was assessed as provisionally safe because the student required supervision. As an experienced clinical teacher, I was able to read the clinical expectations and delineate between satisfactory and provisional in terms of "able to function in changing situations" versus "is not able to function in routine situations." From the standpoint of a layperson and/or ANS, I was concerned that "able to function" and changing versus routine situations would remain vague and unclear.

One teacher specifically included a section that addressed students who may be experiencing difficulties. A section of the course syllabus encouraged these students to discuss concerns with the teacher and/or an individual at the institution's counseling services or other student resource centers, listing locations and contact telephone numbers.

From my standpoint as a former nurse educator, I reflected upon the process of writing a course syllabus. Nurse educators review previous syllabi and may revise the course outline and assignments according to course evaluations by previous students, upcoming class size, and available resources (such as a teaching assistant). In my experience, collaboration with stakeholders rarely occurred while collaboration with

other nurse educators was sometimes undertaken. Representatives from the student body were invited to sit on curriculum committees comprised mainly of faculty members. From the standpoint of students, I questioned how student representatives would negotiate with faculty members in that setting. Perhaps adopting a synthesis of phases of curriculum development and instructional design (Jillings & O'Flynn-Magee, 2006), nurse educators may formulate more relevant curriculum and more inclusive teaching strategies to identify and address the inequities in Aboriginal health and the needs of ANS within a diverse study body.

8.2.3 Required readings

Teachers used the course syllabus to list readings that students were required to review prior to a specific class. In these lists of required readings, teachers provided students with supplementary information in the forms of articles, chapters, and websites. Printed material was typically available for purchase in the form of a reading package at the postsecondary institution's bookstore. I identified seven articles and one website featuring an Aboriginal organization in the required readings section (other than textbooks). Therefore, eight out of 99 required readings or slightly more than 8% referred to Aboriginal peoples. Of these eight readings, one reference provided students with a paragraph that identified that First Nations People compiled 3% of the Canadian population with the majority of First Nations People living in Western Canada. In my analysis of the listed articles and website, four articles and one website (or 5% of required readings) portrayed Aboriginal peoples in a holistic and positive manner. These resources identified Aboriginal peoples' strengths, resilience and inherent knowledge with an emphasis on development of partnerships and/or collaboration with

Aboriginal peoples. Analyzing this discourse, I acknowledged that some nurse educators were beginning to introduce information about nursing practice and Aboriginal peoples. Unfortunately, the majority of nurse educators demonstrated a lack of understanding about the importance of addressing Aboriginal health. The historical influences of colonialism and neo-colonialism on Aboriginal health remained absent in nursing curricula.

8.2.4 Textbooks

In the five reviewed textbooks, I used the index to locate references to Aboriginal peoples, First Nations People, Inuit, or Métis and found one mention of a national Aboriginal health organization. One textbook included information about cultural competence in nursing practice that spanned three pages. As most nursing textbooks originated in the United States, the texts reflected Euro-American nursing.

This finding was important due the fact that: (1) health care needs of Aboriginal peoples are paramount in that in some Canadian hospitals, Aboriginal patients comprise 50% of the patient population, and (2) student nurses require relevant information about the historical and sociopolitical context shaping Aboriginal peoples' health and (3) student nurses require assistance in reflecting on their own culture and positionality in establishing relationships with all patients.

Historically, required textbooks were published mainly in the United States with an emphasis on medical/surgical nursing knowledge and skill acquisition. Although more textbooks are being published in Canada reflecting Canada's health care system and Canadian nursing, I was unable to locate content about Aboriginal health and nursing care of Aboriginal individuals, families, and communities.

From my standpoint as a nurse educator, I acknowledged that teachers evaluate the previous term's textbooks with the cost of textbooks on the part of students in mind. If teachers alter the required textbook, students would be unable to sell them back to the bookstore and incoming students would not be able to buy second hand books at a reduced rate. An article, chapter, or textbook about the historical influences of colonialism and neo-colonialism on Aboriginal health, the diversity within the Aboriginal culture, cultural safety, and health care needs of Aboriginal individuals, families, and communities is greatly needed.

8.2.5 Websites

The websites for the schools of nursing reiterated information included in recruitment brochures. Websites for provincial and national nursing associations presented their mandates to protect the public with links to important legal and ethical documents regarding nursing standards of practice. I was unable to locate any links to the Aboriginal Nurses Association of Canada.

The postsecondary institutions' websites were also reviewed. Their mission was to provide access to postsecondary education to individuals in a respectful environment. Both institutions had policies and procedures available online for students to facilitate claims of discrimination. In terms of language, discrimination was clearly associated with harassment and a respectful learning and work environment. While definitions of discrimination and racism were vague at one postsecondary institution, the other institution's procedure clearly defined discriminatory behavior with reference to more than these categories: ancestry, race, color, ethnic background, and source of income. In the examples of discrimination, application of generalizations and stereotypes was

clearly documented. Students seeking assistance were provided with a list of more than five individuals to approach for assistance. Procedures for informal and formal resolutions were delineated in a clear and comprehensive manner.

8.3 Linking discourse to experience

Analysis of discourse within the two schools of nursing revealed how ANS' experiences were organized and orchestrated by texts.

Getting to an account that explicates *the social relations* of the setting is what and institutional ethnographic account is about. This kind of analysis uses what informants know and what they are observed doing for the analytic purpose of identifying, tracing and describing the social relations that extend beyond the boundaries of any one informant's experiences (or even of all informants' experiences). Translocal and discursively-organized relations permeate informants' understandings, talk, and activities (Campbell & Gregor, 2002, p. 90). Five major "problematics" or "disjunctures"³⁸ were identified from the data. Firstly, I describe how the relationships between ANS and teachers were constructed and framed by the discourse. Secondly, I identify how the culture of nursing education defined a "good" student and how this conflicted with the traditional Aboriginal culture's meaning of a "good" student. The tensions or culture clashes between the culture of nursing education and the Aboriginal culture are explicated. Thirdly, I identify what was absent or exclusionary in the discourse and how this influenced ANS' experiences of exclusion in the schools of nursing. I present the diversity of ANS' experiences, several

³⁸ Institutional ethnographers refer to people's lived experiences in their everyday world as the "problematic" of an investigation (Campbell & Gregor, 2002). In my work, I began by exploring and then explicating particular problematics that ANS' experienced in the schools of nursing. Identifying problematics required me to proceed further and examine the social relations in the schools of nursing (Campbell & Gregor, 2002). Please refer to page 71 to review the meaning of social relations.

paradoxes in ANS' accounts and how these paradoxes influenced nurse educators' experiences teaching ANS and their subsequent decisions about developing inclusive teaching strategies. Finally, I discuss how nursing discourse sustained hegemony.

8.3.1 Relationships between Aboriginal students and faculty

ANS identified that they related fairly instantly and felt more comfortable with faculty members who had experience practicing nursing in northern Aboriginal communities and with faculty members who identified themselves as having Aboriginal ancestry. By sharing these commonalities in experience, ANS were able to feel more connected with theoretical or clinical teachers. When teachers shared this information with ANS, the students perceived that the teachers would be more understanding of their background, the historical context shaping their lives, and the locale where ANS wanted to work as a graduate nurse.

The majority of nursing faculty was middle-aged, middle class, Caucasian women with university degrees and various clinical and community nursing practice experiences in urban centers. ANS perceived that these teachers lacked an understanding of their background, the historical context shaping their lives, and the locale where they wanted to practice as a graduate nurse – an Aboriginal community. ANS described how it was often difficult to acquire a feeling of connection with nursing faculty members.

When ANS identified conflicts that they experienced with teachers, they usually described a conflict with a clinical teacher. On page 140, I presented Aboriginal Nurse #4's account of conforming to the teacher's expectations. This nurse recalled how the teacher clearly required that she follow the Eurocentric interview guide while

conducting a health assessment of an Aboriginal patient and how this conflicted with the ANS' knowledge of culturally appropriate introductions. Because of this ANS' ingenuity and belief to stay "true" to her knowledge of culturally sensitive nursing care, she managed to devise strategies to accomplish "good" nursing practice on both counts. In Aboriginal Nurse #4's account, the behavior change was clear and she was able to develop a way to meet the teacher's expectations. As a student, she realized the negative consequences of not following the teacher's suggestions as she had experienced other ANS acquire failures for not conforming to the teachers' expectations.

In contrast to Aboriginal Nurse #4's situation, many conflicts frequently presented as an unsatisfactory performance review that often came as a surprise to ANS. Being taken off guard was further complicated by a misunderstanding about what the "revised" behavior change might look like. This quote illustrated the power inherent in the evaluative role of the teacher.

Student #24: Then I had one more day before the last day in clinical... She pulled me into the linen closet and she goes, "Okay tomorrow is our last day and I have to tell you 99.9% I am not going to pass you... I feel that you are not ready for Year 4" and [the next day] she made me do more than I did the whole rotation. She made me do everything like and I don't know what the point was (p. 161).

Rather than schedule a private meeting with the ANS at a mutually convenient place and time, the ANS perceived that the teacher pulled her into a linen closet. At the time of this interaction, the ANS was previously unaware of any concerns the teacher had about the student's knowledge application and/or clinical skills. On the last day of clinical, the ANS did not understand the rationale for "doing everything"; whereas, it was clearly understood that the ANS attend that last clinical day and follow requests of the

teacher or the teacher would be 100% certain that she would not pass the ANS. On the last clinical day, the ANS was "hanging by a thread" and uncertain about what revisions were required in her behavior with patients and the teacher.

Some ANS identified tensions in the intergroup relations. This ANS described her perceptions about the relationships between ANS and teachers and identified how she perceived different standards in teachers' evaluations of ANS and Non-Aboriginal nursing students' clinical practice.

Student #31: I just feel that sometimes it's harder to fit in. I think too maybe you are judged a little harder than others, like there is some things that I certainly could raise issues with – like my performance. You know my [clinical] performance is good although there are white people who have or have better performance or get better performance appraisals...I think I work hard or even harder – I am always quick to answer questions (p. 14).

In Ardelle's field note, she acknowledged how emotionally distraught the ANS became when describing clinical experiences. The ANS perceived that she was at the mercy of the clinical teacher's assessments of the ANS' clinical performance

Field Note – At one point in the interview when we were discussing clinical experiences, she became visibly upset and said, "I don't want to talk about it." I shut off the tape recorder and offered her some Kleenex and touched her knee reassuringly. Here is a 4th year nursing student who has received awards and good marks – very upset about what her clinical instructor said to her last week in clinical. She has been crying all weekend and worried. The clinical teacher pulled her aside on the ward when she thought she was doing a really good job and said, "If you don't get better with your skills, I will fail you." She said the instructor wrote down a list of things for her to practice before this week's clinical but she lost the list and is afraid to call the instructor to ask for another copy.

When the ANS agreed, Ardelle continued with the interview. This ANS shared her interpretations of a "threatening note" in that if she was unable to improve the skills, a failing grade would be assigned. This ANS described her terror in acquiring a failing

grade in a clinical course in that it would temporarily shatter her dream of becoming a nurse.

Student #10: And then I got a note stating that if I didn't improve these skills that I could get an F and so I thought, "No, everything that I worked so hard for – no. So after I am done in here, I have to go and see if I can find that note because I ended up misplacing it, where I might have to withdraw from clinical because she said by this week and...I was afraid to contact [the clinical teacher] (pp. 17-18).

In nursing faculty members' accounts of their relationships with ANS, they identified their lack of preparedness and experience teaching ANS. Nurse educators recognized that they required new information and new strategies to connect more meaningfully with ANS (Please see p. 175).

When clinical teachers identified that ANS were performing at unsatisfactory levels, they identified to me that the ANS were unable to apply nursing knowledge in practice settings. As an experienced clinical teacher, I was capable of picturing and understood what the teachers meant about the students' practice level. As an ANS, teachers require different ways of wording exactly what the performance issue is and how the student's change in behavior would look like. Clinical teachers attributed ANS' inability to function as a "good" nurse to cultural differences or complex family problems. Although clinical teachers voiced their concerns for ANS, they identified that their prime responsibility was to protect the public from harm and uphold the practice standards of the professional nursing associations. ANS did not understand that nurse educators were responsible to the public; ANS understood that nurse educators had the power to shatter their dreams of becoming nurses. In the following quote, the experienced nursing instructor explained her conundrum in delineating what was meant by safe and competent nursing practice to an ANS.

Faculty #4: I have been teaching since 1989 – 13 years. No experience with Aboriginals (p. 1)...The [patient] was anxious and becoming increasingly agitated and not cognitively good as he had been and he never wanted to be alone and that was an ongoing issue with him...it was the ANS' obligation to give another patient a medication because I went into see and it was past time when the medication should have been given and the ANS was at the other man's bedside and so I said that she needed to come because we needed to get medications and she came out into the hall and she said, "But I can't leave him." And I said, "What's the problem?" [The ANS said], "He asked me, you are not going to leave me, are you? And he doesn't want to be alone and it's not right for me to leave him alone." We talked about that and I explained the consequences of not leaving him alone was that someone else didn't get their regularly scheduled medications for pain and it would mean that someone else would ultimately be in discomfort and the ANS was really perplexed. She said I don't know you could ever make that decision because in our way we would never leave someone alone who said, "Please don't leave me." So I don't know how you could work in that situation. It was totally foreign to her. And even explaining that we tried to keep volunteers in that room and as much as we could to have someone there was an absolute for her, not something that you tried to work around it, accommodate and do your best with...I saw caring and I saw a desire to help but what I saw more overwhelmingly was a sense of discomfort and unfamiliarity with the setting and a sense of probably being almost overwhelmed (pp. 10 - 11)...Well I tended to think it was my problem and to feel responsible that they weren't getting this material and to agonize about how I could do it differently to help them to grasp what was going on. At some point as I began to get more of a sense of these people I began to get more committed to them and to desperately want them to succeed and so there certainly was some blurring as to whose responsibility is this (pp. 14-15).

In the above excerpt, the faculty member identified how she attempted to use various ways to instill the concepts and related nursing practices that emulated safety and competency in the clinical area. Although she perceived that ANS were overwhelmed in an urban practice setting, she attempted various teaching strategies and dialogued with ANS about differing perceptions of priorities, values, and standards.

In the majority of situations, clinical teachers were less experienced and less likely to initiate different modes of teaching to facilitate learning and applications of concepts and principles into nursing practice. Novice teachers were also less likely to collaborate with ANS about their learning needs and what would work best for the

student. In the following excerpt, the experienced nurse yet novice educator described her reliance and adherence to the nursing discourse to organize how she was required to focus on evaluation of students' performances.

Donna: What kind of assistance do they give you in terms of orientation to clinical instruction?

Faculty #13: Actually I thought very little. There was a meeting about a week before classes started. You received a large learning package which I went home and was overwhelmed with – there was so much to read but I read it. But I found the most assistance I received was from other [clinical teachers] that have done it before. So I called them a lot (p. 2)... Her midterm evaluation – she was satisfactory and that her care was safe. You're kind of assessing where they are in terms of safety and where their clinical skills are and what they need experience in and she was very safe in her clinical practice. She drew up her medications properly, she looked them up, when I asked her what they were – she knew but she's very slow in everything she did. She was very slow in care; she couldn't seem to organize herself and that became another problem going into the final 6 weeks. She was very attached to her worksheet. In fact, she kept talking about her worksheet (p. 13).

Donna: Can you tell me the story about the ANS' medication error?

Faculty #13: In the midterm evaluation she got a "good" under performing safely. She was very consistent with checking drug monograph and she was thorough and safe with meds – oral, subcutaneous and intravenous – identifying them, timing, reactions, why the patient was on it and giving them appropriately. By the time we got the final evaluation, she slipped to an unsatisfactory.

(At this time, the teacher gets a copy of the ANS' clinical evaluation. She flips through the pages)

Faculty #13...the PIP – [the ANS] drew up and administered Morphine 10 mg IV into a patient – she actually administered it. She had been signed off on IV medications so once she's done one correctly... The order on the medication administration record sheet clearly read Morphine 2.5 – 5 mg. So that was an error that I caught... I said the patient didn't get 10 and [the ANS] just looked at me and didn't know what to do. Actually she could have quickly run back and turned off the drip but she didn't. She just seemed really like she did not know what to do. So that was a medication error (p. 16)... So we put this thing [a PIP] in place with a number of parameters that she had to meet. "She will complete care safely and on time, complete charting appropriately. She will assess pain levels on all clients that were administered analgesics, she will give medications on time"... and she came very willingly to discuss this and she signed it very willingly (p. 18)... She was not able to meet the criteria in the PIP and so I discussed it with my course leader and I said, "She's not able to meet them and so she's got to fail" (p. 20).

Given the history of Aboriginal peoples' education in Canada in terms of colonial dominance, assimilation and acculturation, nurse educators' facilitation of learning would require more coaching, mentorship, and facilitation. Rather, the policies and procedures as laid out in the discourse of performance improvement plans, clinical evaluation forms, and clinical probation provided ANS with minimal power and ability to plan, participate, and evaluate their own learning.

In Chapter Six, I identified that nursing faculty members valued a philosophy and practice of providing fairness and equality to all students. By confusing inequality with inequity, many nursing faculty members perceived that ANS acquired more resources than any other student groups, causing them to feel resentment toward ANS. I present how tensions in intergroup relations created more distance between nurse educators and ANS. Participating faculty members indicated that they perceived several inequalities between ANS and other groups within the student nurse population. Although these educators identified that they had limited experience teaching ANS, they held preconceived notions about their lives that caused them to feel resentful towards ANS. Because faculty members had limited knowledge about: (a) influences of colonialism and neo-colonialism on Aboriginal peoples, (b) education on reserves, (c) Access programs, (d) Band sponsorship, (e) funding for Métis students, and (f) their own administration's policies, they assumed that ANS had unlimited resources available to them. Most nursing faculty members questioned why ANS would be allotted funding when other minority groups also needed financial assistance.

These exclusionary factors served to create further distance between nurse educators and ANS. Because of the history of Aboriginal education in Canada, these

factors added "fuel to the fire" and reinforced the existence of hegemony in educational institutions.

Performance improvement plans (PIPs) were developed by clinical teachers and course leaders without collaborating with the student about their self-assessment and identified learning needs. Typically, ANS were not forewarned that a performance improvement plan was underway. While clinical teachers interpreted PIP as helping documents, ANS identified that PIPs conveyed imminent danger. Learning objectives and skill performances were written using nursing jargon. ANS described how they were required to sign this contract even when they disagreed with the teacher's assessment and the written account of what transpired. These policies and procedures continued to subjugate ANS in that they were excluded from the process of appraising their own performance in conjunction with the teacher's clinical evaluation. Student-teacher relationships were revealed with inherent power relations that shaped how ANS were categorized and perceived by faculty and other student groups.

The power gradient that exists in the evaluative context is undeniable. Although student input into evaluation and self-appraisal may be encouraged, true student centeredness may be overshadowed because of faculty accountability for preparing practitioners who are safe to practice and because unlimited time for learning may be practically unrealistic. If these factors can not be changed, at least faculty should be aware of their existence and of their impact on student-centered approaches (Jillings, 2006, pp. 475-476).

8.3.2 The construction of a “good” nurse

As noted by Paterson, Osborne, and Gregory (2004), nursing discourse “simultaneously privileges whiteness and marginalizes those whose difference challenges the ability of teachers and nurses to enact their role” (p. 9). In the culture of nursing education, a “good” nurse was constructed as someone who follows rules well. A “good” nurse was constructed as someone who demonstrates that they care for others by being punctual, organized, diligent, enthusiastic, and who documents their nursing care in a clear and concise manner using appropriate nursing/medical terminology. As described by ANS, Aboriginal nurses, and key informants (KIs), the construction of what constitutes a “good” nurse was based upon Eurocentric values and was traced back to the Victorian era to Florence Nightingale. Student #11 identified that “I think it’s a lot of the old school nursing” (see page 152). KI #5 described her perception of the nursing education.

KI #5: In an undergraduate nursing environment, you’re not really taught to think critically about what you’re learning. You’re taught to learn the rules and the content.

As noted by Aboriginal Nurse #4 (see page 152 for full text), enthusiasm about being a nurse and assessments of patients could be conveyed in various ways.

Aboriginal Nurse #4: She was very quiet, very smart, walk onto the ward and smile at everybody, touch some of the patients on rounds but not say, “good morning” and now say “how are you?” She connected with everyone and most of us and that she was the most marked Native in that kind of behavioral greeting. There is no words spoken...The instructor’s interpretation was you walk in and say “hello, how are you?” (p. 153)

However, this students’ behavior was misinterpreted as unenthusiastic. When the student was unable to conform to visibly and audibly demonstrate enthusiasm, they were required to leave the program. Misunderstandings and misinterpretations of ANS’

behavior was identified numerous times in the data. Student #2 was given a D in professionalism because she was consistently late for her clinical rotations. Although this ANS was having difficulty getting children to daycare and then traveling to the hospital by 7:15 A.M., the ANS did not feel comfortable sharing this problem with the teacher. Because the clinical teacher lacked information about the punctuality problem, the clinical teacher evaluated that the ANS was unprofessional.

In another instance, a faculty member misinterpreted that Student #24 was not paying attention because she was not making eye contact with the teacher (see page 152). An ANS who had adopted traditional Aboriginal values and ways of communicating respect, experienced more difficulty in that they were required to conform to be a "good" nurse. If they were unable to conform, they would be asked or required to leave the nursing program. As identified by several KIs, cognitive dissonance was more likely to occur when ANS had traditional Aboriginal cultural ways. These ANS were required to quite readily change their behavior to demonstrate behaviors that actually conveyed "disrespect" to them.

Student #24: I am raised to be a passive person and to put people ahead of me all the time. And then what I found, the instructor when I was trying to, it seemed like when I was trying to be like that, they wanted me to be like [assertive] and I couldn't do that and then it seemed like it was my fault, that was a negative thing (p. 10).

Several nursing faculty members questioned if the rigidity of the nursing program in terms of how the discourse constructed "good" nursing practice was misconstrued as being racist. These nurse educators pondered the notion of expanding or adopting different worldviews, epistemology, and accomplishing the same nursing practice using different strategies.

Currently, the nursing discourse favors Eurocentric behaviors and problematizes traditional Aboriginal ways of communicating information and respect for others. In fact, ANS and faculty identified instances of culture clashes, especially between the culture of nursing and the traditional Aboriginal culture. For example, an ANS was late for a post conference because she felt that it was disrespectful to leave the room when a physician was sharing "bad news" with the other patient and family. The faculty member valued punctuality and the other patient's privacy.

I identified that clinical evaluation forms were vague in their descriptions of what constituted unsatisfactory to excellent clinical practice. As an experienced clinical teacher, I could decipher the meaning of the written words but as a student nurse, one would have great difficulty identifying from the text what behaviors were required in a clinical setting. Students again were at the mercy of clinical teachers' performance appraisals and often were unaware of why they were punished with PIPs or provided with a failing grade.

8.3.3 Absent and/or exclusionary discourse

I linked the dearth of curricular content about Aboriginal peoples and their health to the invisibility of ANS in Canadian schools of nursing. With minimal attentiveness to Aboriginal health care issues, nurse educators failed to facilitate nursing knowledge and culturally appropriate care for Aboriginal peoples, a growing population in Canada. What message does this provide to nursing students who want to work in Aboriginal communities? What message does this convey to ANS about the relevance of Aboriginal health issues in nursing education? I concluded that perceptions of several KIs were correct in that nursing curricula was developed without consideration of

contextual elements regarding population health and education. These contextual elements were identified as being foundational to curriculum development (Jillings & O'Flynn-Magee, 2006).

I found that recruitment brochures and websites about Access programs were visually identifiable as targeting Aboriginal students. In contrast, recruitment brochures and websites about undergraduate nursing programs were impersonal and lacked photographs of nursing students. Further information such as mention of Access programs or links to Aboriginal student resources was absent. In the schools' recruitment brochures, no words were identified to recruit Aboriginal peoples into the schools.

From the transcripts, most Aboriginal peoples interested in pursuing a nursing education were recruited by word of mouth. If potential applicants heard that an acquaintance or another ANS had a positive experience, they were inclined to apply. Advertisements depicting a culturally diverse group of student nurses (including an Aboriginal student) might be beneficial to show potential applicants how nursing education views the student nurse population base.

Admission policies that lack specific attention to designated seats for Aboriginal peoples blocked potentially excellent clinicians from entering the program as grade point averages were frequently found to be below the competitive cut-off for admission.

As noted by Health Canada (2002), I found that racism was virtually ignored in the discourse within the two participating schools of nursing and the postsecondary institutions. Because "racism" was invisible, one might claim that it does not exist. Information about anti-racist policies was somewhat difficult to locate as it was

embedded in policies and procedures about respectful learning environments and prevention of harassment. Information about anti-racist policies and inclusive learning environments was not included in course syllabi, implying that racism does not occur in schools of nursing and inclusive learning environments are a taken-for-granted feature on the part of nursing faculty members.

I identified several aspects within nursing discourse that contributed to ANS' feelings of exclusion in schools of nursing. These discursive features were: (1) stereotypical portrayal of Aboriginal peoples, (2) exclusive jargon, and (3) limited intergroup relations.

The first discursive feature that I identified was the negative and stereotypical portrayal of Aboriginal peoples in the curriculum. In some instances, nurse educators presented epidemiological statistics about Aboriginal health issues. ANS found the exclusion of positive aspects of Aboriginal peoples and their culture as defamatory and myopic. ANS expressed frustration with nurse educators' construction of Aboriginal health as pathology and deficiency. Several ANS used their personal agency to facilitate further discussion about the context shaping Aboriginal health and the strengths of Aboriginal peoples. However, the majority of ANS expressed that they felt alienated and alone. The majority of ANS were saddened by the one-sided negative portrayal of Aboriginal peoples in the curriculum. These ANS were uncomfortable voicing their thoughts and feelings to Non-Aboriginal students and nurse educators. Questioning how the curriculum was presented was identified as a potentially dangerous act in that "good" nurses followed the rules and would not question their authority.

When some nurse educators addressed Aboriginal health, ANS were not consulted ahead of time to partner with the educator to decipher the best strategy to proceed. When Aboriginal peoples were portrayed in a negative stereotypical manner, these portrayals were shared with all students and unknowingly sustained institutional hegemony, problematic intergroup relations, and colonial dominance. From the standpoint of ANS and faculty, Aboriginal health was framed by using epidemiological statistics that identified higher rates of suicide, diabetes, renal failure and substance abuse. By constructing Aboriginal health in this manner, the contextual and historical influences of colonialism and neo-colonialism on Aboriginal health were absent. By framing Aboriginal health in this manner, I conclude that Aboriginal peoples were blamed.

Because nursing discourse excluded information about Aboriginal nurses in the history of Canadian nursing, one would conclude that Euro-Canadian nursing history is more privileged in the culture of nursing. I located two references to the history of Aboriginal nurses in Canada (Aboriginal Nurses Association of Canada, 1995; Goodwill, 1992); however, these references were not included as required readings. Fieldwork indicated that most ANS were unaware of the existence of the Aboriginal Nurses Association of Canada and references to their website or literature was absent.

The second factor involved how the culture of nursing education used exclusive nursing jargon that vaguely described common concepts to students. For example, I found that in course syllabi, references to nursing practice standards were made with limited specific details about what practice standards actually meant. Common terms, phrases, and slogans in the world of nursing education might be nonsensical to

outsiders making nursing jargon privy to more experienced individuals within the school of nursing. As several ANS entered nursing education with ESL, nursing jargon created further challenges.

In a syllabus for a clinical course, the explanation surrounding various evaluative categories on the clinical evaluation form were understandable to me with my previous experience in nursing education. However, I questioned how understandable the jargon would be for any nursing student and especially a nursing student with ESL. Vague and few references to nursing practice standards and unclear expectations for clinical practice served to confuse and exclude ANS.

8.3.4 Diversity within Aboriginal nursing students' experiences

From the transcripts of interviews with ANS and Aboriginal nurses, I identified diversity within ANS' experiences in regards to their need for recognition of a unique and distinct Aboriginal culture, yet their differing views about being individually singled out as unique and distinctive. While some ANS enjoyed sharing their perspectives and experiences in an Aboriginal culture and community, many ANS were uncomfortable with this situation. Student #2 described her feelings of being exploited for her knowledge and experience in the Aboriginal culture.

Student #2: ...sometimes they push me right to the edge and it takes a lot of willpower not to say anything...Another thing too in class, you're Aboriginal and if they want to do something Aboriginal, they try to get you to be in their team, in their corner...They used me (p. 7).

In contrast to Student #2's feelings and perceptions, Student #26 enjoyed having the opportunity to share her knowledge and experience with her classmates and teacher.

Student #26: I feel good that they are trying to find out. Like I feel privileged to tell about it because why not? (p. 9)

Because of the diversity within the ANS' experiences and the paradoxes presented, nursing faculty identified that prescriptive ways to introduce information about Aboriginal health and related nursing practice would not always facilitate inclusive learning experiences for all ANS. Varcoe and McCormick (2006) explained that:

even in our most well-intentioned efforts we can breathe life into racism.

Engaging in talk about culture, race, racism, and marginalization always both risks reproducing and reinforcing stereotypes and offers opportunity to contest and counter stereotyping, discrimination, and institutional inequity. Thus each teaching/learning moment requires careful scrutiny and reflexivity (p. 438).

My analysis of the nursing discourse identified that a negative stereotypical portrayal of an Aboriginal person was emulated in the case study of Isaac (see page 210). ANS expressed frustration when nursing faculty members inadvertently placed an emphasis on pathologies and deficiencies in Aboriginal health by only presenting negative epidemiological statistics without discussions of positive aspects and strengths in the Aboriginal culture. Student #26 identified the diversity within the ANS group by sharing that a classmate, an ANS, was discouraged and upset by only hearing about deficiencies in Aboriginal health and she proceeded to identify how she was honored to share information about Aboriginal peoples and culture to classmates (see page 158).

Rather than present information about Aboriginal health in a nursing course and have this presentation be perceived as racist, a teacher decided to exclude any information about Aboriginal health in her course. I concluded that the intergroup relations in the school of nursing influenced this teacher's decision as collaboration with ANS and other teachers was not considered as an option to assist the teacher in

introducing the information in a manner that countered stereotyping, discrimination, and institutional inequity.

8.3.5 Hegemony

Would any human being enter nursing education if they were forewarned that they would be required to endure at least five years of poverty, insufficient childcare, possible disruption of the family, confusion about expectations, and resentment from other cultural groups? I am wondering if your answer is related to why this information seemed to be hidden in the nursing discourse. Failing to address limited resources such as financial support, adequate housing in safe neighborhoods, and adequate childcare - sustained the hegemony of the institution. Because of ANS' personal agency, they were able to complete their nursing studies despite the odds against them. Positive consequences were gainful employment, eventual financial independence, and helping others. Negative consequences were disrupted families, unsupervised children and undue stress from poverty as financial struggles occurred for the entire tenure – at least five years.

Hegemony within the institution was visible in the punitive manner in which PIPs and clinical evaluations were conducted. Limited continuing education for faculty and avoidance of current health care issues illustrated the power of some schools of nursing in their disregard for current needs in population health. By failing to embrace and include Aboriginal epistemology with other theories of knowledge and knowledge acquisition, postsecondary institutions limited their capabilities.

8.4 Chapter summary

In this chapter, I described nursing discourse and presented my analysis of how nursing discourse shaped ANS' experiences. By randomly selecting some texts and purposefully selecting others (websites, mission statements, etc.), I mapped how ANS' experiences were discursively organized.

Such analyses are directed toward ruling processes that are pervasive, consequential, and not easily understood from the perspective of any local experience. But the IE approach suggests that an understanding grounded in such a vantage point is possible, and necessary, if we are to build upon excluded perspectives the kind of "map" of institutional processes that might be used in making changes to benefit those subject to ruling relations (DeVault & McCoy, 2001, p. 772).

In particular, I focused on how the nursing discourse shaped student-teacher relationships and widened power differentials. In light of the history of Aboriginal education in Canada, ANS were keenly aware of the power of clinical teachers in the evaluative process. Most ANS chose to conform to clinical teacher's expectations of what constituted a "good" nurse. I identified how the nursing discourse served to construct the notions of a "good" nurse. Nursing discourse served to exclude ANS who followed traditional Aboriginal culture in their communication styles.

I examined the nursing discourse for what was absent and/or exclusionary. Because information about "racism" and anti-racist policies and procedures were difficult to locate, I noted how the discourse shaped the notion that racism does not exist in nursing education.

While several journal articles and one website identified the strengths within the Aboriginal culture and health practices, most nurse educators tended to construct Aboriginal health as pathological and deficient, alienating many ANS. Although several ANS used their personal agency to facilitate others' understanding of the historical influences of colonialism on Aboriginal health and to identify strengths in the Aboriginal culture, the majority of ANS remained silent in the class and used the interview with Ardelle to voice their feelings of frustration and alienation. Most ANS did not perceive that it was "safe" to express their feelings about the negative portrayal of Aboriginal peoples in nursing education.

Nursing discourse reinforced the hegemony of the institution rather than include and empower ANS. Limited policies and procedures were in place to address the provision of adequate resources to support ANS in their tenure. From the standpoint of ANS, references to professional practice standards and a clear explanation of expectations for clinical performances were lacking.

9 SUMMARY AND DISCUSSION

If nursing as a profession is to take difference and race seriously, we can begin by analyzing the Eurocentric roots of our theories. We can refuse to offer only a Eurocentric vision by using articles and books and assignments that draw on a diversity of ideas, ways of knowing, and authors (Varcoe & McCormick, 2006, p. 449).

9.1 Introduction

In this chapter, I provide a summary of the thesis and discuss the findings in light of the theoretical and methodological perspectives as well as the existing knowledge about ANS' experiences. Based upon the findings, I proceed to delineate my vision of ANS' future experiences in a more inclusive learning environment. The empirical findings of this doctoral thesis illustrated how dominant ideologies and nursing discourse shaped the social relations experienced by ANS in the research sites. Institutional hegemony and Eurocentrism within nursing discourse were interwoven and reproduced in the construction of ANS' experiences.

In the first part of this chapter, I provide a summary of the thesis. I reflect upon the background to the study, the research questions, existing knowledge, guiding theoretical and methodological perspectives, method of inquiry, and empirical findings.

In the second section, I examine the findings in light of the chosen tenets from the theoretical and methodological perspectives. Using Aboriginal epistemology, L. Smith's decolonizing methodologies for research and Indigenous peoples, Ramsden's concept of cultural safety, and D. Smith's social organization of knowledge, I further explain how dominant ideologies and nursing discourse served to sustain the hegemony of the schools of nursing and perpetuate exclusion of Aboriginal peoples from a Eurocentric process of learning.

In the third section, I discuss the findings in light of existing knowledge of ANS' experiences. Within the context of what other researchers identified in their studies of ANS' experiences, I identify new knowledge of about factors shaping the construction of ANS' experiences. New knowledge included: (a) intersectionality of gender, race, culture, economic status and geographical distance and ANS' experiences, (b) validation of ANS' experiences of racism, (c) nurse educators' philosophies of equality and fairness versus equity in education, (d) different explanatory models about clinical practice and finally, (e) ANS' incredible personal agency.

In the concluding section of this chapter, I offer recommendations in nursing education, administration, practice, and research. By encouraging nurse educators to collaborate with members of the Aboriginal Nurses Association of Canada, ANS, and Aboriginal communities in the region - more inclusive curricula and pedagogy will be fostered.

9.2 Thesis summary

For my doctoral thesis, I was drawn to examine the construction of undergraduate ANS' experiences in two Canadian schools of nursing. Based upon an urgent need for more Aboriginal nurses and recurring problems recruiting and retaining ANS in schools of nursing, I explored aspects in the local, translocal, and extra local settings to explicate factors that shaped ANS' experiences. I posed these research questions: (1) what are some of the everyday/every night experiences of ANS in Canadian schools of nursing? (2) What are the similarities/differences between the experiences of ANS who originated from an urban versus a northern community? (3) How are the experiences of ANS determined? (4) What are the social relations that

generate the experiences of ANS? And finally, (5) what are the ways in which the sociocultural, political, historical, and ideological construction of nursing education shapes ANS' experiences?

The chosen theoretical and methodological perspectives that guided the study led me to honor the historical context of Aboriginal education and nursing education as well as ANS' experiential and/or embodied knowledge. By engaging in a historical overview of Aboriginal peoples in Canadian education and schools of nursing, I gained insight into how the past continued to shape ANS' experiences.

I identified how existing knowledge about ANS' experiences was socially constructed. I examined the literature for what was present and what was missing. Existing knowledge identified that Aboriginal peoples experienced many struggles or barriers in acquiring postsecondary education. Researchers identified these struggles: (a) inadequate high school preparation, (b) lack of support services, (c) rigid institutional policies and procedures, (d) ethnocentrism, (e) and inadequate funding. What I found missing in the nursing literature was how intergroup relations, racism, curricula and pedagogy influenced ANS' experiences. A study exploring ANS' experiences was needed to explicate how factors in the local, translocal, and extralocal shaped ANS' experiences.

I chose tenets from Aboriginal epistemology (Battiste, 2002; Cajete, 1994), L. Smith's decolonizing methodologies of research with Indigenous peoples (1999), Ramsden's cultural safety (2002), and D. Smith's social organization of knowledge (1987, 1987, 1990, 1999). These tenets influenced the ways that I studied ANS' everyday experience and the ways in which the social, historical, ideological, and

political construction of nursing education shaped ANS' experiences. These theoretical and methodological perspectives provided me with a broad scope to examine how social structures and power issues (social relations) existed in the two Canadian schools of nursing. D. Smith's social organization of knowledge provided me with a starting and ending point for the research – the experience of the ANS. By working with an Aboriginal research assistant and the advisory council, I acquired guidance in reflecting upon the standpoint of the ANS.

I identified that critical ethnography was the most appropriate method of inquiry to address the research questions. I used various sources of data in the purposive sample: interviews with 31 ANS about their everyday lives, interviews with 5 Aboriginal nurses to grasp an understanding of historical influences on ANS' experiences, interviews with 24 members of the nursing faculty, and interviews with 16 key informants who were identified as individuals knowledgeable about the context that shaped ANS' experiences. The research assistant and I conducted 200 hours of fieldwork and documented reflective and descriptive field notes. I also randomly selected and analyzed 135 texts to explicate how nursing discourse shaped ANS' experiences.

Using a computer software program to organize the data, I used a three-phase technique to import data and analyze the texts (transcripts, field notes, and nursing texts, forms, documents). Using Townsend's three analytic processes (1996) previously described on page 114 and guided by Campbell and Gregor's work (2002) and an experienced institutional ethnographer on my thesis committee, I analyzed the data by: (1) identifying ANS' experiences, (2) linking ANS' experiences with faculty's experiences

teaching ANS, and then (3) mapping how ANS' experiences were shaped by various texts originating from outside and inside the school of nursing. Scientific and ethical quality was maintained throughout the project. A limitation of the study was that no fieldwork was conducted in clinical practice areas, so accounts of ANS' experiences in practice settings were deciphered from interviews with ANS and clinical teachers. Because of my previous ten year experience as a clinical teacher and by consulting the research assistant and the advisory council members, I was able to delineate the actualities of ANS' stories.

Most of the ANS were mature First Nations women who acquired Band sponsorship to fund their postsecondary education. Fifty percent of participants had between one and three children and 25% of participants were single parents. Many participants relocated from a northern Aboriginal community to an urban centre to acquire their nursing education. Thus, these participants were presented with a "culture shock" and required to help themselves and their families adjust to an urban lifestyle away from the support of extended family and friends.

The majority of participating faculty members was comprised of middle-aged, Euro-Canadian women with more than five years experience in schools of nursing. However, most faculty members acknowledged that they had limited preparation and experience teaching ANS.

ANS described their journeys to and through the schools of nursing as long and arduous. A typical time frame for completion of undergraduate nursing education for ANS was five years. ANS' expressed that their major concern was inadequate funding. ANS experienced jeopardy that was magnified by the intersectionality of gender, race,

culture, economic status and geographical distance from social supports. For example, lack of available and affordable childcare resources was a major detriment to the ANS' in that actual provision of childcare or worrying about children's safety prevented ANS from focusing on studying. In several situations, ANS were unable to acquire childcare and were required to send children back to home communities to be cared for by extended family members. As some ANS' culture placed a high value for family ties and a pull towards home communities and the land, ANS experienced conflicts when the culture of nursing education placed a higher value on academia. ANS' used their strong personal agency to persevere despite the odds.

Although health care needs of Aboriginal peoples are paramount in Canada, nursing curricula lacked inclusion of crucial information about Aboriginal health and nursing care of Aboriginal peoples. I linked the invisibility of information about Aboriginal health to the invisibility of ANS in schools of nursing. By ignoring the specific health care needs of Aboriginal peoples in Canada's growing Aboriginal population, nurse educators and administrators sustain colonial dominance and neo-colonialism. The historical context shaping Aboriginal health and information about diversity with the Aboriginal culture were also missing. Dominant ideologies and nursing discourse perpetuated the hegemony of postsecondary institutions.

9.3 Discussion

In this section, I reflect upon the study's findings in light of the guiding tenets within the theoretical and methodological perspectives. This section is organized according to findings related to: (1) Aboriginal epistemology, (2) decolonizing

methodologies for research and Indigenous peoples, (3) cultural safety, (4) social organization of knowledge, and (5) the study's contributions to nursing knowledge.

9.3.1 Aboriginal epistemology

In contrast to the pedagogical strategy of storytelling in the oral tradition, nursing curricula and pedagogy primarily involved texts with nurse educators sharing small vignettes of their experiential knowledge in lectures to large groups of students. The majority of information was shared in the form of course syllabi, websites, textbooks, and additional readings.

...there exists a contingent which actually prefers the antiquated methods of teaching; possibly it is preferred because it is familiar; possibly it is easier to be a passive learner than an active participant in one's learning. Embracing the old methodology may be more cost-effective, particularly during periods of a nursing shortage. Lecturing 100 students in an auditorium who passively listen and take notes is more efficient than forming multiple small student learning groups with a faculty facilitator. The question remains: What approach best prepares the nurses of the future? (Dattilo & Brewer, 2006, p. 343)

As Aboriginal epistemology believes that context shapes experiences, I was unable to locate the inclusion of the influences of colonialism and neo-colonialism on Aboriginal peoples, culture, and health in the curriculum and in the educators' understandings and portrayals of Aboriginal peoples. Also, faculty members lacked an understanding of how the history of education of Canada's Aboriginal peoples continues to shape ANS' relationships and interactions with teachers. Clinical nursing courses did not offer an Aboriginal community or an Aboriginal community health clinic as an option

for nursing students to study and practice their skills. The invisibility of Aboriginal health issues and the invisibility of the actual nursing practice in Aboriginal communities was incongruent with Aboriginal epistemology in that schools discounted the importance of experiential knowledge and the “pull to the land.”

Upon reflecting upon Aboriginal epistemology, I was drawn to Kirkness and Barnhardt's (1991) recommendation that postsecondary institutions embrace Aboriginal epistemology, as it would indeed enhance higher learning. By offering postsecondary students a variety of worldviews and a variety of views about knowledge and knowledge acquisition, a richer educational experience would entail. As noted by Marker (1998) and a key informant, teaching Non-Aboriginal students and ANS about Aboriginal spirituality may be less important than facilitation of an understanding of the historical influences and the social determinants of health on Aboriginal peoples.

9.3.2 Decolonizing methodologies

L. Smith's (1999) seminal work on decolonizing methodologies for research and Indigenous peoples reinforced the importance of speaking about ANS' personal agency and illuminating the hegemony within the institution rather than the subordination of the ANS. With L. Smith's focus on self-determination for Indigenous peoples, I was guided to identify ANS as pillars of strength who succeeded despite the odds against them. Many postsecondary students could learn coping strategies by hearing the stories of ingenuity, perseverance, and strength from ANS.

I was further guided to collaborate with the RA, members of the Advisory council and members of the Aboriginal Nurses Association of Canada. This methodological perspective guided me to protect all participants' identities and prevent “backlash” to

ANS continuing their long and arduous journeys through participating schools of nursing.

I transposed L. Smith's terminology into decolonizing nursing education as a way to reflect recommendations for more inclusive policies and teaching strategies by collaborating with experts in Aboriginal health and education (Aboriginal peoples). Tenets from this methodological perspective reinforced the necessity to provide nursing faculty and nursing students with information about the influences of colonialism and neo-colonialism on Aboriginal people, their culture, and their health.

L. Smith's work (1999) also guided me in examining how self-determination can promote more student-centered approaches to learning. Dattilo and Brewer (2006) stated that, "The student-centered approach may be jeopardized if the traditional opinion is held that students are not capable of making decisions about their learning" (p. 343). Student-centered approaches require change on the part of the teacher and the learner and challenges what has historically been practiced in nursing education (Datillo & Brewer, 2006). By collaborating with Aboriginal nurses and the Aboriginal Nurses Association of Canada, nurse educators and administrators can gather and learn more specific recommendations about curriculum development to promote Aboriginal health and its related nursing practice.

9.3.3 Cultural safety

Using cultural safety as a backdrop to reflect upon the findings (Ramsden, 2002), I found that schools of nursing perpetuated the hegemony of postsecondary institutions by ignoring Aboriginal peoples as a distinct and important population group. Although several nurse educators used reflexivity to identify how their privileged positionalities

widened the power differentials between them and ANS, most faculty members failed to formally recognize their inherent power over ANS. Most educators chose to see themselves in helping roles rather than oppressors.

This backdrop assisted me in illuminating how administrators and educators took for granted the organizational culture of nursing education. Participating faculty members rarely reflected upon their own beliefs and mores within the culture of nursing education. A recognition of nursing education as a distinct organizational culture was severely lacking. As an interpretive lens, cultural safety prompted me to unmask the ways that school policies, curricula, pedagogy, and research (the existing knowledge) perpetuated colonial and neo-colonial approaches to recruitment and retention of ANS. As individuals and groups often take the everyday for granted, the need for ongoing critical reflexivity is imperative to enhance inclusive recruitment and retention strategies.

By using cultural safety as a lens, I was poised to observe the intergroup relations within the schools of nursing. Different explanatory models were used to formulate understandings of expectations of clinical practice and the learning environment. Because nurse educators were unaccustomed to reflect upon their standpoint and acknowledge their part in an organizational culture, nursing discourse perpetuated mixed messages and misinterpretations. By coming to a shared understanding of these concepts, more trusting relationships will be fostered.

9.3.4 Social organization of knowledge

The social organization of knowledge provided me with a backdrop in my review of the literature. I examined how the existing knowledge of ANS' experiences was socially constructed. Because D. Smith (1986, 1987, 1999) provided a theorized basis

for critically examining textually mediated discourses, I explored how ideas and social forms of consciousness might originate within and outside of the school of nursing. I was poised to begin from the standpoint of ANS and end with it. My analysis of nursing texts required that I assume the standpoint of ANS to decipher how texts would be perceived by ANS. With the dominant Euro-Canadian culture generally failing to recognize Aboriginal peoples as a distinct and important part of the population, the invisibility of Aboriginal health in nursing curricula was perpetuated.

9.3.5 Study's contributions to new knowledge

I identify how this study shed new light and broadened the understanding of ANS' experiences in two Canadian schools of nursing. What is important is how this study's findings can be generalized to the social processes within other Canadian schools of nursing that enroll ANS. This study explicated how intergroup tensions were unwittingly fueled by misconceptions and misunderstandings.

9.3.5.1 Intersectionality

When I reviewed existing knowledge of Aboriginal peoples' experiences in postsecondary education, I identified six inter-related struggles or stressors and contributed to hostile learning environment. These struggles were: (a) inadequate high school preparation, (b) lack of support services, (c) rigid institutional policies and procedures, (d) ethnocentrism, and (e) inadequate funding. Although some ANS acquired their primary and secondary education in Aboriginal communities and identified their education as "substandard," this struggle was achievable, "doable," and minimal in comparison with the intersectionality of other variables.

Findings of this study validated previous knowledge; however, this study broadened the scope of these inter-related variables in that I identified how gender, race, culture, economic status, and geographical distance from social supports magnified the situation of jeopardy for ANS.

Supporting the findings of Health Canada (2002), many ANS struggled to access and acquire available and affordable childcare. Infant and toddler spots as well as before school and after school programs were difficult to locate in the urban centre. Also, infant and toddler spots were expensive. Daycares were unable to accommodate early morning drop-offs to facilitate ANS' prompt arrival for clinical placements placing some ANS in a precarious position in that they failed to achieve the clinical teacher's expectations of punctuality.

Validating Ryan's (1995) findings that relocation to an urban centre affected the entire family and that the stereotypical image of Aboriginal women is that they are "bad" mothers, this study further explicated how families were disrupted as several ANS described how they were required to send children back to extended families in home communities. The disruption of Aboriginal families continued as affordable and available childcare resources were unavailable to ANS in the urban center. Other ANS described how they struggled with childcare decisions in that sometimes, school-aged children were required to be home alone unsupervised as before and after school programs had no available spots. Focusing on nursing studies was difficult when ANS were worried about the safety of their children.

I defer my discussion of race as a contributing variable under the following subsection entitled "Racism exists." I proceed to discuss how the variable of culture

contributed to ANS' experiences. The second research question required that I examine similarities and differences between ANS that originated in urban and rural or northern sites. The majority of ANS were from rural or northern Aboriginal communities. The data indicated that ANS with a traditional culture experienced what several key informants' identified as cognitive dissonance and what Marker (2001) identified as the clash zone. I found that ANS with a traditional culture were more apt to experience conflicts with teachers as differing explanatory models about values, nursing knowledge and practice collided.

The next contributing factor in intersectionality is ANS' economic status. All First Nations participants were successful at acquiring Band sponsorships. This study supporting findings by Health Canada (2002) in that Band sponsorships were grossly inadequate. Band sponsorships failed to adequately provide ANS and their families with basic needs let alone support studentships and other living expenses in a Canadian urban centre. This study added further information about ANS' inability to provide food for their families as my fieldwork identified that several ANS were required to rely upon food banks.

This study also validated the findings of Health Canada (2002) in that the Métis participants were the most disenfranchised economically. Métis organizations only supported the last 15 months of a postsecondary education as they embraced a back to work program rather than education of professionals. What this study added to Health Canada's work (2002) was that perpetuation of a dismal economic status for ANS created undue stress as these participants were more focused on worrying about how to meet the families' basic needs and feed their children than how to study nursing.

Findings of this study indicated that ANS felt a pull towards families and home communities as Aboriginal epistemology strongly links human beings to their place and/or their land. Unfortunately, their economic status prevented regular long distance phone calls and limited their ability to travel and access these important social supports. This study indicated that ANS adapted to their geographic isolation by using each other as social supports.

9.3.5.2 Racism exists

I located six studies that indicated that Aboriginal peoples experienced racism within postsecondary institutions. Additionally, Walsch's project with a sample of 5 ANS identified ANS' experiences of racism. This study contributed to a growing body of nursing knowledge that racism exists in nursing education and requires the attention of administrators, educators, and students.

As racism, ethnocentrism, Eurocentrism, classism, patriarchy, heterosexism, and homophobia characterize contemporary Western societies, they also pervade nursing education. Although their influence is always present and unavoidable, nursing educators can choose the extent to which they explicitly address these issues...Over the past several years we have come to believe that without direct attention to the existence and effects of racism (inextricably intertwined with other forms of oppression), we, by default, allow our learning spaces (classrooms, online courses, and clinical settings) to be more open to discriminatory and stereotypical thinking, leaving extant power dynamics unchallenged (Varcoe & McCormick, 2006, p. 439).

This study identified how passive and active forms of racism were exhibited in various learning environments. When administrators, educators, and students were unable to build partnerships and/or communities and were constrained in working with difference in epistemologies, values, interpretations, and skin color, discriminatory and stereotypical thinking, statements, and behaviors went unchallenged. ANS were offended when Aboriginal peoples were portrayed in a negative stereotypical manner. Although some ANS facilitated further learning by sharing historical influences of colonialism and neo-colonialism on Aboriginal peoples, the majority of ANS had no voice.

Findings of this study supported previous work by Hagey and MacKay (2000) and Paterson, Gregory, and Osborne (2004) in that I identified the hegemony of the postsecondary institution in policies and procedures within the schools of nursing. The jeopardy experienced by ANS was perpetuated as the discourse failed to identify policies and procedures whereby needed resources such as housing, childcare and financial aid were made available. As racism was absent from course syllabi and anti-racist policies and procedures were located under the auspices of a respectful environment and prevention of harassment, racism could be misconstrued as nonexistent and anti-racist policies could be misinterpreted as not necessary.

9.3.5.3 Equality and fairness versus equity

Exploring the experiences of 24 nursing faculty members teaching ANS broadened the scope of previous findings by Dickerson and Neary (1999). This study contributed to nursing scholarship in that I was able to discover how nurse educators valued a sense of providing equality and fairness to all students in their teachings.

Many nurse educators believed that a foundational philosophy of providing equal and fair time and instruction to all students ensured that they were doing "right" and "good." Many nurse educators were concerned about being perceived as biased for and/or against individual students and student groups in a culturally diverse student population by teaching/evaluating more and differently.

This study identified that many nurse educators misunderstood the gross inequities inherent in being an ANS educated in an Aboriginal community. In a milieu where faculty members highly valued equality and fairness, they expressed their resentment about their perceptions that ANS were provided with more resources than any other student group. These faculty members shared their perceptions that ANS were well funded by their Bands and ultimately, Canadian taxpayers. Without understanding the contextual component that disadvantaged Aboriginal peoples, many nurse educators perceived that ANS were a privileged group. ANS were able to identify similar resentments from Non-Aboriginal students. Intergroup relations were influenced by faculty members' and Non-Aboriginal students' misunderstandings of equality, fairness, and equity.

9.3.5.4 Differing explanatory models

This study's findings expanded upon Dickerson, Neary, and Hyche-Johnson's (2000) work with Aboriginal graduate nursing students in that I was able to link ANS' and clinical teachers' experiences. This linkage facilitated the ability to conceptually formulate how ANS and faculty members' viewed the same situation differently.

This study indicated that the history of Aboriginal education in Canada greatly influenced ANS' experiences in schools of nursing. Because of different explanatory

models interplaying in nursing knowledge and practice, faculty members were unable to convey their messages and expectations in an understandable manner to ANS. Nurse educators were responsible to prevent harm to the public by ensuring student nurses were practicing safe and competent care. Although nurse educators relied heavily upon nursing practice standards, reference to professional nursing practice standards in course syllabi was rare. Reliance upon different explanatory models created tensions between ANS and teachers. Data from key informants reaffirmed how historical influences of colonialism and neo-colonialism on Aboriginal education continued to shape the disconnection experienced by both ANS and nurse educators. Nurse educators held a clear understanding of what constituted: (a) nursing knowledge, (b) practice expectations, and (c) practice standards. *Nurse educators were able to focus on the task at hand, while ANS struggled to decipher the true meaning of nursing jargon - verbal and written descriptions of nursing knowledge and practice expectations. Rather than address ANS' claims of racism, many teachers chose to focus on the students' accountability and achievement of skill performance.

Because of a different explanatory model used by ANS, they were perplexed when conflicts emerged between them and their teachers. History played an important role in preventing clearer communications and trust in the intergroup relations within schools of nursing.

9.3.5.5 Personal agency

The research assistant and I were awestruck with the ANS' stories of assertiveness, relentlessness, and ingenuity. In keeping with Health Canada's findings (2002) in *Against the odds*, I also found rich descriptions of ANS' personal agency.

Many ANS described how they used their ingenuity to access available resources and maneuver themselves within the educational system. They devised strategies to make the system work to their best interests despite insurmountable barriers.

9.4 Recommendations

Based on the study's findings, I formulated key recommendations in my vision for more inclusive teaching strategies and anti-racist policies. Recommendations are organized according to target group.

9.4.1 Professional nursing associations

In light of the growing Aboriginal population in Canada and New Zealand's success at incorporating the concept of cultural safety in nursing education and practice, I recommend that the Aboriginal Nurses Association of Canada collaborate with Canadian Nurses Association and Canadian Association of Schools of Nursing to further explore the incorporation of the concept of cultural safety into nursing curricula, accreditation, RN exams, and standards of practice.

9.4.2 Educational administrators

To provide the Canadian public with an adequate supply of Aboriginal nurses, schools of nursing are encouraged to support access programs for socially and economically disadvantaged applicants with designated and guaranteed seats for ANS. This study's findings confirmed that ANS require the provision of visible, accessible, and adequate resources. I recommend that postsecondary institutions collaborate with Aboriginal organizations to establish resources and personnel to assist beginning students in finding safe housing, transportation, and personal supports to adjust to the

culture shock of city life, large campus, distance from extended families, and new experiences of racism (Ryan, 1995). ANS require affordable and reliable childcare that facilitates their early morning attendance at clinical practice sites and prevents the disruption of families.

Again by collaborating with the Aboriginal Nurses Association of Canada, educational administrators could explore provision of a formal mentorship program to facilitate support for ANS as they navigate through the culture of nursing education. Aboriginal nurses and senior nursing students who volunteer to participate could be paired up with ANS in a formal mentorship program.

Seminars and workshops about the historical influences of colonialism and neo-colonialism on Canada's Aboriginal peoples, their culture, and their health may provide faculty members and student nurses with a venue to facilitate reflection of their own cultural values, beliefs, and mores. By reflecting on one's positionality prior to interacting with patients, power inequities will be acknowledged and honored.

As most faculty claimed to have limited experience teaching ANS, collaboration with Aboriginal student resource centers and cultural diversity experts might assist nurse educators to identify and share insights into more inclusive teaching strategies. These strategies could be implemented and shared with other faculty members to examine their effectiveness.

Educational administrators must revisit anti-racist policies within their institutions to ensure that ANS' claims of anti-racist behaviors are adequately examined within the various learning environments. These policies need to become more visible to prevent further practices of ignoring ANS' claims of racism.

ANS would definitely expect that I identify their financial struggles and formulate recommendations to increase financial support. One ANS suggested that First Nations and Métis organizations conduct a needs assessment to fully understand their financial strife. To prevent the further subjugation of ANS living in poverty, ANS need adequate funding to reduce stressors related to their current inability to provide nutritional food, adequate clothing and safe shelter for their families. These women endured many challenges and are committed on learning how to become a nurse to make a better future. The Canadian people benefited from the use of Aboriginal land and resources and we need to honor our treaty agreements and provide ANS with adequate funding and adequate education.

9.4.3 Educators and researchers

Reflecting upon my research design now that the study is completed, I think that this study was an appropriate starting point to explicate the social relations in Canadian schools of nursing. Fortunately, I had the assistance and expertise of many Aboriginal peoples who were committed to this study. These individuals were able to guide me to consider the standpoint of ANS. Given that, I would like to suggest the need for further research in ANS' experiences by the Aboriginal Nurses Association of Canada. Using historical narratives and incorporating the oral tradition into further research, richer descriptions of ANS' experiences may be elucidated.

Further research is needed to examine how different explanatory models influence student-teacher relationships, patient-nurse relationships, and nurses' relationships in a multidisciplinary team. The findings of this study showed that teachers' understanding of nursing knowledge and practice were in juxtaposition to

ANS' understandings as this information was privy to experienced nurses. Nurse educators require information into how to formulate common understandings of professional practice standards and clinical expectations to all students.

Based upon the limitations that I did not conduct fieldwork in clinical or community settings, it would be beneficial to conduct further studies about ANS' experiences in these research sites. This research may further illuminate the dominant ideologies and discourse that ANS experience in their practice settings as well as what graduate Aboriginal nurses may be facing in their current and future employment facilities.

A future study recruiting more male ANS would be beneficial to reinforce the implications of gender as a variable in the intersectionality of gender, race, culture, and economic status. As only 2 male ANS were recruited, it was detrimental to attend to their gender in the excerpts of transcripts and field notes because of the imminent danger of them being identifiable.

Clearer messages to all students might be enhanced if all course syllabi referred students to specific nursing practice standards pertinent to the specific course. Nursing practice standards need to be conveyed to students in an understandable manner. Nurse educators and researchers could confirm students' understandings of nursing practice standards by affirming students' own interpretation of the meaning of practice standards.

Nurse educators would benefit by reflecting on the culture of nursing education. The first step in adopting cultural safety as a concept is to reflect upon one's own culture and positionality (Varcoe & McCormick, 2006). Nursing education in Canada

may have an overarching "culture" to it, but each individual school of nursing will have its own subculture and both require further exploration and illumination.

9.4.4 Aboriginal organizations

With the support of postsecondary institutions and schools of nursing, Bands and Métis organizations may choose to lobby the federal, provincial and territorial governments for funding that meets the basic needs of today's ANS. As Métis students were the most disenfranchised financially, Métis associations require additional supports to address the needs of Métis peoples pursuing postsecondary education in fields other than subordinate positions.

9.5 Conclusion

By conducting a critical ethnography in two Canadian schools of nursing, I explicated social tensions and identified how text-mediated discourse shaped the social relations experienced by ANS. These social relations are generalizable to other social relations occurring in Canadian schools of nursing that enroll ANS. By incorporating:

- more visible and specific anti-racist policies in postsecondary institutions,
- a contextual foundation in the development of curricula and instructional design,
- reflexivity in the development of inclusive teaching strategies, and
- resources to foster more humane living conditions,

I believe the educational experiences of ANS in Canadian schools of nursing will be enhanced. When ANS speak positively about their experiences in Canadian schools of nursing, more Aboriginal peoples will venture into the realm of nursing education and subsequently, nursing practice. With a growing Aboriginal population and the health

needs of Aboriginal peoples, future nurses (Non-Aboriginal and Aboriginal) require knowledge and skills to provide culturally appropriate care to Aboriginal individuals, families, and communities. A critical analysis of nursing discourse revealed that nursing education requires further work in concepts of inequity, privilege, power, and cultural safety. My role will be to share the study's findings with others and encourage further exploration of these concepts. Finally, I'd like to return to the beginning of Chapter One where the Anonymous Aboriginal nurse identified that a researcher studying this topic would need to be brave. In hindsight, I acknowledge that my naivety about ANS' experiences and the political nature of the study far outweighed my courage. I identified that the ANS were the courageous ones, not me.

REFERENCES

- Aboriginal Nurses Association of Canada. (1995). *Working together for quality nursing care and healing: 1975 - 1995*. Ottawa: Author.
- Aboriginal Nurses Association of Canada. (2002a). *Aboriginal nursing educational needs analysis: Results of a national survey – Summer 2002*. Ottawa, ON: Author.
- Aboriginal Nurses Association of Canada. (2002b). *Supervision of nurses in First Nation communities: What are the gaps? A literature review and analysis*. Ottawa, ON: Author.
- Aboriginal Nurses Association of Canada. (2004a). *Response to the First Minister conference: Health care summit on Aboriginal people in Ottawa, September 13, 2004*. Ottawa, ON: Author. Retrieved November 1, 2004, from <http://www.newswire.ca/en/releases/archive/September2004/20/c1339>.
- Aboriginal Nurses Association of Canada. (2004b). *The Aboriginal Nurses Association of Canada recommends a national survey to assess the nursing workforce available for Aboriginal communities*. Retrieved February 9, 2005, from <http://www.newswire.ca/en/releases/archive/December2004/14/c5370.html?view=print>
- Aboriginal Nurses Association of Canada. (2005). *Aboriginal nursing education symposium: Final report*. Ottawa: Author.
- Adams, M. (1992). Cultural inclusion in the American college classroom. In N. Van Note Chism and L. Border (Eds.), *Teaching for Diversity - New Directions for Teaching and Learning*, 49, (pp. 5 – 17). San Francisco: Jossey-Bass Publishers.
- Alcoff, L. (1991). The problem of speaking for others. *Cultural Critique*, Winter, 5-31.
- Andersen, M. (1993). Studying across difference: Race, class, and gender in qualitative research. In J. Stanfield, and R. Dennis (Eds.), *Race and ethnicity in research methods* (pp. 39-52). Newbury Park: Sage Publications.
- Anderson, G. (1989). Critical ethnography in education: Origins, current status, and new directions. *Review of Educational Research*, 59(3), 249-270.
- Anderson, J. (1991). Reflexivity in fieldwork: Toward a feminist epistemology. *Image: Journal of Nursing Scholarship*, 23(2), 115-118.

- Anderson, J., Perry, J., Blue, C., Browne, A., Henderson, A., Khan, K.B., Kirkham, S.R., Lynam, J., Semeniuk, P., & Smye, V. (2003). "Rewriting" cultural safety within the postcolonial and postnational feminist project: Toward new epistemologies of healing. *Advances in Nursing Science*, 26(3), p. 196-214.
- Annett, K. (2001). *Hidden from history: The Canadian holocaust (2nd ed.)*. Vancouver: The Truth Commission into Genocide in Canada.
- Archibald, J., & Urion, C. (1995). Honoring what they say: Postsecondary experiences of First Nations graduates. *Canadian Journal of Native Education*, 21(1), 4-9.
- Arvizu, D.R. (1995). The care voice and American Indian college students: An alternative perspective for student development professionals. *Journal of American Indian Education*, 34(3), 1-17.
- Assembly of Manitoba Chiefs. (1999). *Education framework agreement*. [On-line]. Retrieved September, 20, 2000, from www.mbchiefs.mb/efa/research.
- Back, L. (2004). Ivory towers? The academy and racism. In I. Law, D. Phillips and L. Tierney (Eds.), *Institutional racism in higher education* (pp. 1-6). Sterling, VA: Trentham Books.
- Bainbridge, R. (2004). *Recruiting and retaining Aboriginal nursing students*. Paper presented at the Aboriginal Nursing Education Symposium, Ottawa, November 23, 2004.
- Barman, J., Hebert, Y., & McCaskill, D. (1987). The challenge of Indian education: An overview. In J. Barman, Y. Hebert, & D. McCaskill (Eds.), *Indian education in Canada, Volume 2: The Challenge* (pp. 1-21). Vancouver: University of British Columbia Press.
- Battiste, M. (2002). *Indigenous knowledge and pedagogy in First Nations education: A literature review with recommendations*. Ottawa: National Working Group on Education and the Minister of Indian Affairs, Indian and Northern Affairs Canada. Retrieved November 22, 2005, from http://www.ainc-inac.gc.ca/pr/pub/krw/ikp_e.html
- Berkowitz, S., & Barrington, D. (1998). Race and ethnicity: Intergroup relations in a multi-ethnic society. In H. Ball, S. Berkowitz, and M. Mzamane (Eds.), *Multicultural education in colleges and universities: A transdisciplinary approach* (pp. 3 – 33). Mahwah, New Jersey: Lawrence Erlbaum Associates, Publishers.
- Brink, P. (1990). Cultural diversity in nursing: How much can we tolerate? In J. McCloskey and H. Grace (Eds.), *Current issues in nursing (3rd ed.)* (pp. 521-527). St. Louis, MO: C.V. Mosby.

- Browne, A. (2003). *First Nations women and health care services: The sociopolitical context of encounters with nurses*. Unpublished doctoral dissertation, University of British Columbia, Vancouver, British Columbia, Canada.
- Browne, A., Fiske, J., & Thomas, G. (2000). First Nations women's encounters with mainstream health care services and systems. Vancouver, Canada: British Columbia Centre of Excellence for Women's Health. Retrieved January 18, 2005, from <http://www.bccewh.bc.ca/PDFs/firstnationsreport.pdf>
- Browne, A., Johnson, J., Bottorff, J., Grewal, S., & Hilton, B.A. (2002). Recognizing discrimination in nursing practice. *Canadian Nurse*, 98(5), 24-31.
- Buerhaus, P., & Auerbach, D. (1999). Slow growth in the United States of the number of minorities in the RN workforce. *Image: Journal of Nursing Scholarship*, 31(2), 179-183.
- Burns, G. (1998). Factors and themes in Native education and school boards/First Nations tuition negotiations and tuition agreement schooling. *Canadian Journal of Native Education*, 22, 1, 53-67.
- Cajete, G. (1994). *Look to the mountain: An ecology of Indigenous education*. Durango, Colorado: Kivaki Press.
- Calliste, A. (1996). Antiracism organizing and resistance in nursing: African Canadian women. *Canadian Reviews of Sociology & Anthropology/RCSA*, 33(3), 362-390.
- Campbell, A., & Davis, S. (1996). Faculty commitment: Retaining minority nursing students in majority institutions. *Journal of Nursing Education*, 35(7), 298-303.
- Campbell, M. (1995). Teaching accountability: What counts as nursing education? In M. Campbell, & A. Manicom (Eds.), *Knowledge, experience, and ruling relations* (pp. 221 - 233). Toronto: University of Toronto Press Incorporated.
- Campbell, M. (1998). Institutional ethnography and experience as data. *Qualitative Sociology*, 21(1), 55-73.
- Campbell, M. (2000). Knowledge, gendered subjectivity, and the restructuring of health care: The case of the disappearing nurse. In S. Neysmith (Ed.), *Restructuring caring labour: Discourse, state practice, and everyday life* (pp.186-208). Don Mills, ON: Oxford University Press.
- Campbell, M. & Gregor, F. (2002). *Mapping social relations: A primer in doing institutional ethnography*. Aurora, ON: Garmond Press.
- Campbell, M., & Jackson, N. (1992). Learning to nurse: Plans, accounts, and action. *Qualitative Health Research*, 2, 475-496.

- Campbell, M., & Manicom, A. (1995). *Knowledge, experience, and ruling relations: Studies in the social organization of knowledge*. Toronto: University of Toronto Press Incorporated.
- Canadian Nurses Association and Canadian Association of Schools of Nursing. (2004). *The national student and faculty survey of Canadian schools of nursing, 2002-2003*. Retrieved November 11, 2005 from http://cna-aiic.ca/cna/documents/pdf/publications/Table4_2002_2003_e.pdf
- Canales, M. (2000). Toward an understanding of difference. *Advances in Nursing Science*, 22(4), 16-31.
- Cannella, G., & Reiff, J. (1994). Preparing teachers for cultural diversity: Constructivist orientation. *Action in Teacher Education*, 16(3), 37-45.
- Care, W. D. (2003). The learning experiences of First Nations nursing students in a distance education environment. In J. Oakes, R. Riewe, K. Wilde, A. Edmunds, and A. Dubois (Eds.), *Native voices in research* (pp. 82-94). Winnipeg: Aboriginal Issues Press.
- Carspecken, P.F. (1996). *Critical ethnography in educational research: A theoretical and practical guide*. New York: Routledge.
- Castellano, M. (2002). Updating Aboriginal traditions of knowledge. In G. Sefa Dei, B. Hall, and D. Rosenberg (Eds.), *Indigenous knowledges in global contexts: Multiple readings of our world* (pp. 21-36). Toronto: University of Toronto Press.
- Castellano, M., Davis, L., & Lahache, L. (2000). *Aboriginal education: Fulfilling the promise*. Vancouver, Canada: UBC Press.
- Cook, L., & Petit de Mange, B. (1995). Gaining access to Native American cultures by non-native American nursing researchers. *Nursing Forum*, 30(1), 5-10.
- Coup, A. (1996). Cultural safety and culturally congruent care: A comparative analysis of Irihapeti Ramsden's and Madeleine Leininger's educational projects for practice. *Nursing Praxis in New Zealand*, (11), 1, 4-11.
- Crow, K. (1993). Multiculturalism and pluralistic thought in nursing education: Native American worldview and the nursing academic worldview. *Journal of Nursing Education*, 32(5), 198-204.
- Culley, L. (1996). A critique of multiculturalism in health care: The challenge for nurse education. *Journal of Advanced Nursing*, 23(3), 564-570.
- Culley, L. (1997). Ethnicity, health and sociology in the nursing curriculum. *Social Sciences in Health*, 3(1), 28-40.

- Cummins, J. (1995). Discursive power in educational policy and practice for culturally diverse students. In D. Corson (Ed.), *Discourse and power in educational organizations* (pp. 191- 209). Cresskill, New Jersey: Hampton Press, Inc.
- Dattilo, J., & Brewer, M.K. (2006). Historical influences of nursing curriculum. In L. Young and B. Paterson (Eds.), *Teaching nursing: Developing a student-centered learning environment* (pp. 325-346). Philadelphia: Lippincott Williams & Wilkins.
- Dei, G.J.S., Hall, B., & Rosenberg D.G. (2000). *Indigenous knowledges in global contexts: Multiple readings of our world*. Toronto: University of Toronto Press Incorporated.
- DeMontigny, G. (1995). The power of being professional. In M. Campbell, & A. Manicom (Eds.), *Knowledge, experience, and ruling relations: Studies in the social organization of knowledge* (pp. 209 – 220). Toronto: University of Toronto Press Incorporated.
- DeMontigny, G. (2002). Which side are you on?: IE and Loyalty in social work. Paper presented at the Institutional Ethnography Network Meeting, Victoria, British Columbia, Canada.
- Denzin, N. & Lincoln, Y. (1998). Introduction: Entering the field of qualitative research. In N. Denzin and Y. Lincoln (Eds.), *Strategies of qualitative inquiry* (pp. 1 – 34). Thousand Oaks: Sage Publications.
- Deprez, P. & Lithman, Y.G. (1973). *Two papers on Canadian Indians - Education and economic development: The case of Indian reserves in Canada and The capitalization of a traditional pursuit: The case of wild rice in Manitoba*. Winnipeg: University of Manitoba Center for Settlement Studies.
- DeVault, M. (1990). Talking and listening from women's standpoint: Feminist strategies for interviewing and analysis. *Social Problems*, 37(1), 96-116.
- DeVault, M. (1995). Ethnicity and expertise: Racial-ethnic knowledge in sociological research. *Gender & Society*, 9(5), 612-631.
- DeVault, M., & McCoy, L. (2001). Institutional ethnography: Using interviews to investigate ruling relations. In J. Gubrium, & J. Holstein (Eds.), *Handbook of interview research: Context and method* (pp. 751-776). Thousand Oaks: Sage Publications, Inc.
- Dickerson, S.S., & Neary, M. (1999). Nursing faculty experiences teaching Native Americans. *Journal of Transcultural Nursing*, 10(1), 56-64.

- Dickerson, S.S., Neary, M., & Hyche-Johnson, M. (2000). Native American graduate nursing students' learning experiences. *Journal of Nursing Scholarship*, 32(2), 189-196.
- Dowd, T., & Eckerman, A. (1992). Cultural danger or cultural safety: Remote area health services. *The Australian Nursing Journal*, 21,6, 11-12.
- Downey, R. (2004). *Aboriginal nursing education: A new paradigm*. Paper presented at the Aboriginal Nursing Education Symposium, Ottawa, Canada.
- Dyck, I., & Kearns, R. (1995). Transforming the relations of research: Towards culturally safe geographies of health and healing. *Health & Place*, 1(3), 137-147.
- Ermine, W. (1995). Aboriginal epistemology. In M. Battiste and J. Barman (Eds.), *First Nations education in Canada: The circle unfolds* (pp. 101 – 112). Vancouver: UBC Press.
- Fiske, J. (1995). Political status of Native Indian women: Contradictory implications for Canadian state policy. *American Indian Culture and Research Journal*, 19(2), 1-30.
- Fixico, D. (2003). *The American Indian mind in a linear world: American Indian studies and knowledge*. New York: Routledge.
- Fleras, A., & Elliott, J.L. (1999). *Unequal relations: An introduction to race, ethnic, and Aboriginal dynamics in Canada* (3rd ed.). Scarborough, ON: Prentice Hall Allyn and Bacon Canada.
- Funkhouser, S.W., & Moser, D. (1990). Is health care racist? *Advances in Nursing Science*, 12(2), 47-55.
- Furuta, B., & Lipson, J. (1990). Where is cultural diversity in the student body? In J. McCloskey and H.K. Grace (Eds.), *Current issues in nursing* (3rd ed.) (pp. 528-533). St. Louis: C.V. Mosby.
- Geertz, C. (1983). *Local knowledge: Further essays in interpretive anthropology*. New York: Basic Books, Inc., Publishers.
- Goldberger, N.R. (1996). Cultural imperatives and diversity in ways of knowing. In N.R. Goldberger, J.M. Tarule, B.M. Clinchy, & M.F. Belenky (Eds.), *Knowledge, difference, and power: Essays inspired by women's ways of knowing* (pp. 335 – 369). New York: Basic Books.
- Goodwill, J.C. (1992). Organized political action: Indian and Inuit nurses. In A. Baumgart and J. Larsen (Eds.), *Canadian nursing faces the future* (2nd ed.), (pp. 597-609). St. Louis: Mosby Year Book.

- Gordon, T., Holland, J., & Lahelma, E. (2001). Ethnographic research in educational settings. In P. Atkinson, A. Coffey, S. Delamont, J. Lofland, and L. Lofland (Eds.), *Handbook of ethnography* (pp. 188-203). Thousand Oaks, CA: Sage Publications.
- Government of Canada. (2003). *Indian residential schools resolution Canada*. Retrieved November 1, 2004, from http://www.irsr-rqpa.gc.ca/english/key_events.html
- Grahame, P., & Grahame, K.M. (2000/2001). Official knowledge and the relations of ruling: Explorations in institutional ethnography. *Journal of pedagogy, pluralism & practice, Issue5*. Retrieved October 30, 2004, from <http://www.lesley.edu/journals/jppp/5/grahame.html> .
- Griffiths, M., & Tagliareni, M.E. (1999). Outcomes from Project IMPART: Challenging traditional assumptions about minority students in nursing education. *Nursing and Health Care Perspectives, 20* (6), 290-295.
- Guba, E., & Lincoln, Y. (1994). Competing paradigms in qualitative research. In I. Denzin and Y. Lincoln (Eds.), *Handbook of qualitative research* (pp. 105-117). Thousand Oaks: Sage Publications.
- Hagey, R., & MacKay, R. (2000). Qualitative research to identify racist discourse: Towards equity in nursing curricula. *International Journal of Nursing Studies, 37*, 45-56.
- Haig-Brown, C. (1995). *Taking control: Power and contradiction in First Nations adult education*. Vancouver: UBC Press.
- Hampton, E. (1995). Towards a redefinition of Indian education. In M. Battiste and J. Barman, *First Nations education in Canada: The circle unfolds* (pp. 5-46). Vancouver: UBC Press.
- Harding, S. (1991). *Whose science? Whose knowledge? Thinking from women's lives*. Ithica, NY: Cornell University Press.
- Hart, M. (2002). *Seeking mino-pimatisiwin: An aboriginal approach to healing*. Halifax: Fernwood Publishing.
- Hart-Wasekeesikaw, F. (1999). Aboriginal health nursing - A cultural approach. *Aboriginal Nurse, 14*(2), 3.
- Health Canada. (2002). *Against all odds: Aboriginal nursing*. Ottawa, ON: Author.

- Henderson, J.Y. (1995). Treaties and Indian education. In M. Battiste and J. Barman (Eds.), *First Nations education in Canada: The circle unfolds* (pp. 245-271). Vancouver: UNC Press.
- Heyl, B.S. (2001). Ethnographic interviewing. In P. Atkinson, A. Coffey, S. Delamont, J. Lofland, & L. Lofland (Eds.), *Handbook of ethnography* (pp. 369-383). Thousand Oaks: Sage Publications.
- Holstein, J., & Gubrium, J. (2003). *Inside interviewing: New lenses, new concerns*. Thousand Oaks, CA: Sage Publications.
- Hoover, J., & Jacobs, C. (1992). A survey of American Indian college students: Perceptions toward their study skills/college life. *Journal of American Indian Education*, 32(1), 21-29.
- Hornett, D. (1989). The role of faculty in cultural awareness and retention of American Indian college students [Special Issue]. *Journal of American Indian Education*, 29(1), 12-18.
- Huff, D. (1997). *To live heroically: Institutional racism and American Indian education*. Albany: State University of New York Press.
- Huffman, T. (1991). The experiences, perceptions, and consequences of campus racism among Northern Plains Indians. *Journal of American Indian Education*, 30(2), 25-34.
- Indian and Northern Affairs Canada. (2004). *Canada, Aboriginal nurses, and nurses unions to boost number of Aboriginal people in nursing*. Retrieved February 9, 2005, from http://www.ainc-inac.gc.ca/nr/prs/s-d2004/2-02525_e.html
- Indian Residential School Society. (2004). *Indian Residential School historical overview*. Retrieved November 2, 2004, from http://www.irsr-rqpa.gc.ca/english/key_events.html
- Jackson, A., Smith, S. & Hill, C. (2003). Academic persistence among Native American college students. *Journal of College Student Development*, 44(4), 548-565.
- Jackson, E. (1993). Whiting out the difference: Why U.S. nursing research fails Black families. *Medical Anthropology Quarterly*, 7(4), 363-385.
- Jackson, N. (1995). 'These things just happen': Talk, text, and curriculum reform. In M. Campbell, & A. Manicom (Eds.), *Knowledge, experience, and ruling relations: Studies in the social organization of knowledge* (pp. 164 – 180). Toronto: University of Toronto Press Incorporated.

- James, P. (1992). Native Americans and higher education. *College Student Affairs Journal*, 12(1), 56-62.
- Jillings, C. (2006). Barriers to student-centered teaching: Overcoming institutional and attitudinal obstacles. In L. Young and B. Paterson (Eds.), *Teaching nursing: Developing a student-centered learning environment* (pp. 467-483). Philadelphia: Lippincott Williams & Wilkins.
- Jillings, C., & O'Flynn-Magee, K. (2006). Knowledge and knowing made manifest: Curriculum process in student-centered learning. In L. Young and B. Paterson (Eds.), *Teaching nursing: Developing a student-centered learning environment* (pp. 383-402). Philadelphia: Lippincott Williams & Wilkins.
- Joho, K., & Ormsby, A. (2000). A walk in beauty: Strategies for providing culturally competent nursing care to Native Americans. In M.L. Kelley & V.M. Fitzsimmons (Eds.), *Understanding cultural diversity: Culture, curriculum, and community in nursing* (pp. 209 - 218). Toronto: National League of Nursing Press/Jones and Barlett Publishers.
- Kavanagh, K., Absalom, K., Beil, W., & Schliessmann, L. (1999). Connecting and becoming culturally competent: A Lakota example. *Advances in Nursing Science*, 21(3), 9-31.
- Kearns, R., & Dyck, I. (1996). Cultural safety, biculturalism and nursing education in Aotearora/New Zealand. *Health and Social Care in the Community*, 4(6), 371-380.
- Keitner, B. (1999). American Indian, Alaska Native nurses blaze trail of culturally competent care. *American Nurse*, 31(3), 16.
- Khayatt, D. (1995). Compulsory heterosexuality: Schools and lesbian students. In M. Campbell, & A. Manicom (Eds.), *Knowledge, experience, and ruling relations: Studies in the social organization of knowledge* (pp. 149 - 163). Toronto: University of Toronto Press, Incorporated.
- Kinsman, G. (1995). The textual practices of sexual rule: Sexual policing and gay men. In M. Campbell, & A. Manicom (Eds.), *Knowledge, experience, and ruling relations: Studies in the social organization of knowledge* (pp. 80-95). Toronto: University of Toronto Press, Incorporated.
- Kinsman, G. (2002). Sociology for changing the world: Political activism and institutional ethnography. Paper presented at the meeting of the Institutional Ethnography Network Conference, Victoria, British Columbia, Canada.

- Kirkham, S.R. (2000). *"Making sense of difference": The social organization of intergroup relations in health care provision*. Unpublished doctoral dissertation, University of British Columbia, Vancouver, British Columbia, Canada.
- Kirkham, S.R., & Anderson, J. (2002). Postcolonial nursing scholarship: From epistemology to method. *Advances in Nursing Science*, 25(1), 1-17.
- Kirkham, S.R., Smye, V., Tang, S., Anderson, J., Blue, C., Browne, A., Coles, R., Dyck, I., Henderson, A., Lynam, M.J., Perry, J., Semeniuk, P., & Shapera, L. (2002). Rethinking cultural safety while waiting to do fieldwork: Methodological implications for nursing research. *Research in Nursing & Health*, 25, 222-232.
- Kirkness, V. (1999). Aboriginal education in Canada: A retrospective and a prospective. *Journal of American Indian Education*, 39(2), 14-30.
- Kirkness, V., & Barnhardt, R. (1991). First Nations and higher education: The four R's – Respect, relevance, reciprocity, responsibility. *Journal of American Indian Education*, 30(3), 1-15.
- Kleinfeld, J., Cooper, J., & Kyle, N. (1987). Postsecondary counselors: A model for increasing Native Americans' college success. *Journal of American Indian Education*, 27(1), 9-16.
- Kulig, J. (1987). Native American registered nurses and state board examinations. *Journal of American Indian Education*, 26(2), 29-38.
- Kulig, J., & Thorpe, K. (1996). Teaching and learning needs of culturally diverse post-R.N. students. *Canadian Journal of Nursing Research*, 28(2), 119-123.
- Ladson-Billings, G. (1994). What we can learn from multicultural education research. *Educational Leadership*, 51(8), 22-26.
- Ladson-Billings, G. (1995). Multicultural teacher education: Research, practice, and policy. In J. Banks and C. Banks (Eds.), *Handbook of research in multicultural education* (pp. 747-759). New York: Macmillan.
- Lather, P. (1991). *Getting smart: Feminist research and pedagogy with/in the postmodern*. New York: Routledge.
- Law, I., Phillips, D. & Turney, L. (2004). *Institutional racism in higher education*. Sterling, VA: Trentham Books.
- Lin, R., LaCounte, D., & Eder, J. (1988). A study of Native American students in a predominantly white college. *Journal of American Indian Education*, 27(3), 8-15.

- Long, C., & Nelson, K. (1999). Honoring diversity: The reliability, validity, and utility of a scale to measure Native American resiliency. *Journal of Human Behavior in the Social Environment*, 2(1/2), 91-107.
- Lynam, M.J., & Young, R. (2000). Towards the creation of a culturally safe research environment. *Health*, 4(1), 5-23.
- MacLeod, M., Kulig, J., Stewart, N., & Pitblado, R. (2004). *Nursing practice in rural and remote Canada: Final report to Canadian Health Services Research Foundation*. Retrieved October 20, 2004, from <http://www.ruralnursing.unbc.ca>.
- Makinauk, J. (2003). Aboriginal students' perspectives on university life. In J. Oake, R. Riewe, A. Edmunds, A. Dubois & K. Wilde (Eds.), *Native voices in research* (pp. 95-104). Winnipeg: Aboriginal Issues Press.
- Marker, M. (1997). Indian education in the Pacific Northwest: The missing research. *Tribal College Journal*, 4 (2), 16-21.
- Marker, M. (1998). Going Native in the academy: Choosing the exotic over the critical. *Anthropology & Education Quarterly*, 29(4), 473-480.
- Marker, M. (2000a). Ethnohistory and Indigenous education: A moment of uncertainty. *History of Education*, 29 (1), 79-85.
- Marker, M. (2000b) Lummi identity and white racism: When location is a real place. *International Journal of Qualitative Studies in Education*, 3(3), 401-414.
- Marker, M. (2001). Economics and local self-determination: Describing the clash zone in First Nations education. *Canadian Journal of Native Education*, 24 (1), 30-45.
- Marker, M. (2004a). The four r's revisited: Some reflections on First Nations and higher education. In L. Andres and F. Finlay (Eds.), *Student affairs: Experiencing higher education*. Vancouver: UBC Press.
- Marker, M. (2004b). Theories and disciplines as sites of struggle: The reproduction of colonial dominance through the controlling of knowledge in the academy. *Canadian Journal of Native Education*, 28(1/2), 102-111.
- Marker, M. (2005). "It was two different times of the day, but in the same place": Coast Salish high school experience in the 1970s. *BC Studies*, Winter/2004/2005, 144, 89-110.
- Martin, D. (1997). *An ethnographic study examining the quality of worklife issues of outpost nurses in northern Manitoba*. Unpublished Master's thesis. Winnipeg: University of Manitoba.

- Martin, D. (2002). Reticence: Studying Aboriginal nursing students' experiences. Paper presented at the Putting Institutional Ethnography into Practice Conference, Victoria, British Columbia, Canada.
- Martin, D., & Gregory, D. (1996). An ethnographic study examining quality of worklife issues of outpost nurses in northern Manitoba. In J. Oakes & R. Riewe (Eds.), *Issues in the North*, 1, (pp. 7-15). Edmonton, AB: Canadian Circumpolar Institute.
- Martin, D., & Kipling, A. (2005). Decolonizing nursing education: How nursing discourse shapes the everyday world of Aboriginal nursing students in Western Canadian schools of nursing. Paper presented at the Chicago Institute of Nursing Education Conference, Nursing Education in the 21st Century: Beyond the Textbook, Chicago, Illinois, June 21, 2005.
- Martin, D., & Kipling, A. (2006). How nursing discourse shapes Aboriginal nursing students' experiences. Paper presented at the Western Region Canadian Association of Schools of Nursing Conference, Edmonton, February 25, 2006.
- Mautner, T. (1996). *The Penguin dictionary of philosophy*. London: Penguin Books.
- Maxwell, J. (1998). Designing a qualitative study. In L. Bickman & D. Rog (Eds.), *Handbook of applied social research methods* (pp. 69 - 100). Thousand Oaks: Sage Publications.
- Mclsaac, E. (2000). Oral narratives as a site of resistance. In G. Sefa Dei, B. Hall, & D. G. Rosenberg (Eds.), *Indigenous knowledges in global contexts: Multiple readings of our world* (pp. 89-101). Toronto: University of Toronto Press Incorporated.
- McClelland, A. (2005). Reflection: Is it a critical element in nursing education in the 21st century? Paper presented at the Chicago Institute for Nursing Education, Nursing Education in the 21st Century: Beyond the Textbook Conference, Chicago, Illinois.
- Miller, S. (1997). Multiple paradigms in nursing: Postmodern feminisms. In S Thorne & V. Hayes (Eds.), *Nursing praxis: Knowledge and action* (pp. 140 – 156). Thousand Oaks: Sage Publications.
- More, A. (1987). Native Indian learning styles: A review for researchers and teachers. *Journal of American Indian Education*, 27(1), 17-29.
- Morse, J. (1998). Designing funded qualitative research. In N. Denzin and Y. Lincoln (Eds.), *Strategies of qualitative inquiry* (pp. 56-85). Thousand Oaks: Sage.

- Nairn, S., Hardy, C., Parumal, L., & Williams, G. (2004). Multicultural or anti-racist teaching in nursing education: A critical appraisal. *Nurse Education Today*, 24(3), 188-195.
- Natives face nursing shortage. (2001, April 18). *Winnipeg Free Press*, p. B1.
- O'Neill, B. (1998). Institutional ethnography: Studying institutions from the margins. *Journal of Sociology & Social Welfare*, 25(1), 127-144.
- O'Neill, B. (2002). Issues in analysis and writing up: Social work education from the standpoint of gay men and lesbians. Paper presented at the Institutional Ethnography Network Conference, Victoria, British Columbia, Canada.
- Orb, A., Eisenhauer, L., & Wynaden, D. (2001). Ethics in qualitative research. *Journal of Nursing Scholarship*, 33(1), 93-96.
- Paterson, B., Osborne, M., & Gregory, D. (2004). How different can you be and still survive? Homogeneity and difference in clinical nursing education. *International Journal of Nursing Education Scholarship*, 1(1), Article 2. Retrieved December 15, 2004, from <http://www.bepress.com/ijnes>
- Pence, E. (2002). Community activism on violence against women: Reading agency texts. Paper presented at the Institutional Ethnography Network Conference, Victoria, British Columbia, Canada.
- Penketh, L. (2000). *Tackling institutional racism: Anti-racist policies and social work education and training*. Bristol, UK: Policy Press.
- Perry, B. (2002). American Indian victims of campus ethnoviolence. *Journal of American Indian Education*, 41(1), 1-22.
- Phillips, D. (2000). Language as constitutive: Critical thinking for multicultural education and practice in the 21st century. *Journal of Nursing Education*, 39(8), 365-372.
- Pinikahana, J., Manias, E., & Happell, B. (2003). Transcultural nursing in Australian nursing curricula. *Nursing and Health Sciences*, 5, 149-154.
- Plumbo, A. (1995). Living in two different worlds or living in the world differently: A qualitative study with American Indian nurses. *Journal of Holistic Nursing*, 13(2), 155-173.
- Polaschek, N. (1998). Cultural safety: A new concept in nursing people of different ethnicities. *Journal of Advanced Nursing*, 27(3), 452-457.
- Puzan, E. (2003). The unbearable whiteness of being (in nursing). *Nursing Inquiry*, 10(3), 193-200.

- Ramsden, I. (1993). Kawa Whakaruruhau. Cultural safety in nursing education in Aotearoa, New Zealand. *Nursing Praxis in New Zealand*, 8(3), 4-10.
- Ramsden, I. (1995). *Cultural safety: Implementing the concept*. Paper presented at The Social Force of Nursing and Midwifery Conference, Wellington, New Zealand.
- Ramsden, I. (2000). Cultural safety/Kawa whakaruruhau ten years on: A personal overview. *Nursing Praxis in New Zealand*, 15(1), 4-12.
- Ramsden, I. (2002). *Cultural safety and nursing education in Aotearoa and Te Waipounamu*. Unpublished doctoral dissertation, University of Wellington, Victoria, New Zealand. Retrieved online: January 18, 2005, from <http://culturalsafety.massey.ac.nz/thesis.htm>
- Ramsden, I., & Page, J. (1993). Changing the state examination. *New Zealand Nursing Journal*, 86(2), 30.
- Rankin, J. (2003). 'Patient satisfaction': Knowledge for ruling hospital reform – An institutional ethnography. *Nursing Inquiry*, 10(1), 57-65.
- Rather, M. (1994). Schooling for oppression: A critical hermeneutical analysis of the lived experience of the returning RN student. *Journal of Nursing Education*, 33(6), 263-271.
- Redwood-Campbell, L., MacDonald, W., & Moore, K. (1999). Residents' exposure to aboriginal health issues: Survey of family medicine programs in Canada. *Canadian Family Physician*, 45, 325-330.
- Reyhner, J. (1992). American Indian culture and school success. *Journal of American Indian Education*, 32(1), 30-39.
- Rhodes, R. (1998). Holistic teaching/learning for Native American students. *Journal of American Indian Education*, 27(2), 21-29.
- Richardson, S. (2004). Aotearoa/New Zealand nursing: from eugenics to cultural safety...*Nursing Inquiry*, 11(1), 35-42.
- Roberson, M. & Kelley, J. (1996). Using Orem's theory in transcultural settings: A critique. *Nursing Forum*, 31(3), 22-28.
- Ryan, J. (1992). Formal schooling and deculturation: Nursing practice and the erosion of Native communication styles. *The Alberta Journal of Educational Research*, 38(2), 91-103.

- Ryan, J. (1995). Experiencing urban schooling: The adjustment of Native students to the extra-curricular demands of a post-secondary education program. *Canadian Journal of Native Studies*, 211-230.
- Sandelowski, M. (1995). Sample size in qualitative research. *Research in Nursing & Health*, 18, 170-183.
- Schmitt, M. (2002). It's time to revalue nursing education research. *Research in Nursing & Health*, 25, 423-424.
- Sefa Dei, G., Hall, B., & Rosenberg, D.G. (2000). *Indigenous knowledges in global contexts: Multiple readings of our world*. Toronto: University of Toronto Press.
- Seibold, C. (2000). Qualitative research from a feminist perspective in the postmodern era: Methodological, ethical and reflexive concerns. *Nursing Inquiry*, 7, 147-155.
- Sharma, S. (2004). Transforming the curriculum: The problem with multiculturalism. In I. Law, D. Phillips, and L. Turney (Eds.), *Institutional racism in higher education* (pp. 105-117). Sterling, USA: Trentham Books.
- Smith, D. (1986). Institutional ethnography: A feminist method. *Resources for Feminist Research*, 15(1), 6-13.
- Smith, D. (1987). *The everyday world as problematic: A feminist sociology*. Toronto: University of Toronto Press.
- Smith, D. (1990). *The conceptual practices of power: A feminist sociology of knowledge*. Boston: Northeastern University Press.
- Smith, D. (1999). *Writing the social: Critique, theory and investigations*. Toronto: University of Toronto Press.
- Smith, G. (1995). Accessing treatments: Managing the AIDS epidemic in Ontario. In M. Campbell, & A. Manicom (Eds.), *Knowledge, experience, and ruling relations: Studies in the social organization of knowledge* (pp. 18 – 34). Toronto: University of Toronto Press Incorporated.
- Smith, L.T. (1999). *Decolonizing methodologies: Research and Indigenous peoples*. London: Zed Books.
- Smye, V., & Browne, A. (2002). 'Cultural safety' and the analysis of health policy affecting aboriginal people. *Nurse Researcher*, 9(3), 42-56.

- St. Denis, V. & Hampton, E. (2002). *Literature review on racism and the effects on Aboriginal education..* Prepared for Minister's National Working Group on Education, Indian and Northern Affairs Canada, Ottawa, Ontario. Retrieved April 15, 2005 from http://www.ainc-inac.gc.ca/pr/pub/kw/rac_e.pdf
- Struthers, R., & Littlejohn, S. (1999). The essence of Native American nursing. *Journal of Transcultural Nursing*, 10(2), 131 - 135.
- Tate, D., & Schwartz, C. (1993). Increasing the retention of American Indian students in professional programs in higher education. *Journal of American Indian Education*, 33(1), 21-31.
- Tejeda, C., Espinoza, M., & Gutierrez, K. (2003). Toward a decolonizing pedagogy: Social justice reconsidered. In P. Trifonas (Ed.), *Pedagogies of difference: Rethinking education for social change* (pp. 10 – 40). New York: RoutledgeFalmer.
- Thomlinson, E. (1992). Education: One means of caring for clients and nurses in isolated northern settings. In D. Gaut (Ed.), *A global agenda for caring...Fourteenth annual caring research conference, Melbourne, Australia* (pp. 81-93). New York: National League for Nursing Press.
- Thompson, K. (1993). Self-governed health. *Canadian Nurse*, 89(8), 29-32.
- Thorne, S. (1997). Praxis in the context of nursing's developing inquiry. In S. Thorne and V. Hayes (Eds.), *Nursing praxis: Knowledge and action* (pp. ix – xxi). Thousand Oaks: Sage Publications.
- Tierney, W. (1992). *Official encouragement, institutional discouragement: Minorities in academe – The Native American experience*. Norwood, NJ: Ablex.
- Townsend, E. (1996). Institutional ethnography: A method for showing how the context shapes practice. *The Occupational Therapy Journal of Research*, 16(3), 179-199.
- Trifonas, P. (2003). *Pedagogies of difference: Rethinking education for social change*. New York: RoutledgeFalmer.
- Tuckett, A. (2004). Qualitative research sampling: The very real complexities. *Nurse Researcher*, 12(1), 47-61.
- Tullman, D.F. (1992). Cultural diversity in nursing education: Does it affect racism in the nursing profession? *Journal of Nursing Education*, 31(7), 321-324.
- Usher, K., Miller, M., Lindsay, D., & Miller, A. (2005). Challenges faced by Indigenous Nursing students and strategies that aided their progress in the course: A descriptive study. *Contemporary Nurse*, 19(1-2), 17-31.

- Varcoe, C., & McCormick, J. (2006). Racing around the classroom margins: Race, racism and teaching nursing. In L. Young and B. Paterson (Eds.), *Teaching nursing: Developing a student-centered learning environment*. (pp. 437 – 466). New York: Lippincott Williams & Wilkins.
- Waldram, J., Herring, D.A., & Young, T. Kue. (1995). *Aboriginal health in Canada: Historical, cultural, and epidemiological perspectives*. Toronto: University of Toronto Press.
- Walsch, L. (1995). Factors and strategies for success of Aboriginal students in the Southern nursing program at Red River Community College. Unpublished manuscript, University of Manitoba, Winnipeg, Canada.
- Weaver, H. (1999). Transcultural nursing with Native Americans: Critical knowledge, skills, and attitudes. *Journal of Transcultural Nursing*, 10(3), 197-202.
- Weaver, H. (2001). Indigenous nurses and professional education: Friends or foes? *Journal of Nursing Education*, 40(6), 252-258.
- Womack, R. (1997). Enhancing the success of Native American nursing students. *Nurse Educator*, 22(4), 14,31,43,47. Retrieved November 27, 2004 from <http://gateway.ut.ovid.com/gwl.ovidweb.cgi>
- Wotherspoon, T., & Satzewich, V. (2000). *First Nations: Race, class, and gender relations*. Regina: Canadian Plains Research Centre.
- Young, L., & Paterson, B. (2006). *Teaching nursing: Developing a student-centered learning environment*. Philadelphia: Lippincott Williams & Wilkins.
- Yurkovich, E. (1997). *Factors that enabled success of Native American baccalaureate nursing graduates at Montana State University from 1986-1995*. Unpublished doctoral dissertation, Montana State University, Bozeman, Montana.

Appendix A
Letter Requesting Permission for Access



School of Nursing

T201-2211 Wesbrook Mall
Vancouver, B.C. Canada V6T 2B5

Tel: (604) 822-7417

Fax: (604) 822-7466

August 6, 2004

X

School of Nursing
Postsecondary Institution
City, Province
Postal Code

Dear X,

I am requesting your permission for me to access students, faculty, staff, and pertinent textual documents such as faculty and university policies and procedures, web pages, course syllabuses, and nursing textbooks for the purposes of a research study. The proposed doctoral thesis is a research study in which I will conduct an institutional ethnography to examine the experience of Aboriginal nursing students in a Canadian school of nursing. Findings of the project will be used to formulate recommendations to enhance recruitment and retention of Aboriginal people in nursing - an important issue in nursing education.

The research questions are:

1. What are the experiences of Aboriginal nursing students in a Western Canadian school of nursing?
2. What are the similarities/differences between the experiences of Aboriginal nursing students who originated from an urban versus a northern community?
3. How are the experiences of Aboriginal nursing students determined?
4. What are the social relations that generate the experience of Aboriginal nursing students?
5. What are the ways in which the sociocultural, political, historical, and ideological construction of nursing education shapes Aboriginal nursing students' experiences?

I am currently seeking ethical approval for the study from the University of British Columbia, the postsecondary institution and the other postsecondary institution. Please see the enclosed Request for Ethical Renewal/Revisions document that will explain the purpose and nature of the study. The Social Sciences and Humanities Research Council and the Michael Smith Foundation for Health Research have provided funding.

If you provide permission for me to conduct the study at your facility, I will need you or a designate to assist me with the following requirements for the study:

1. Forward an e-mail letter to faculty and staff. This e-mail will introduce the study, the research assistant (RA) and me to the faculty and invite them to participate.
2. Forward an e-mail letter to clinical education facilitators (CEFs) and student advisors, inviting them to participate. Preliminary findings indicated that CEFs and student advisors were important resources for Aboriginal nursing students. (Participating faculty will donate 1 hour of their time for the interview.)
3. Forward a letter via Canada Post to all students who have identified themselves as Aboriginal. The letter will invite Aboriginal nursing students to attend an informational session about the study and invite them to participate. The study will reimburse the faculty for the cost of postage. (Participating Aboriginal nursing students will be donating 1.5 hours of their time: 30 minutes for an initial informal meeting, and 1 hour for the interview.)
4. Post provided advertisements, inviting Aboriginal nursing students to attend the informational session and to participate in the study, on student bulletin boards in the nursing building and in the Access Program.
5. Forward an e-mail to all faculty members, requesting them to welcome the RA to each of their classes to introduce herself, the study, and invite students who identify themselves as Aboriginal to attend an informal informational session. Time: 5 – 10 minutes.
6. Provide a room in the nursing building for an informational session (refreshments provided by study).
7. Provide an interview room for the RA to conduct face-to-face interviews with participating Aboriginal students.

Data for this study includes field notes, interview transcripts, and textual analysis of the institution's mission statement, nursing textbooks, web pages, and course syllabi. In the transcripts, field notes, and in future dissemination of the findings, the name of the institution and the names of participating students and faculty will not be used. Students and faculty

Appendix D**Recruitment Letter – Aboriginal Nursing Students**

Appendix F

Letter Inviting Key Informant to Participate

Appendix G

Interview Guides

Interview Guide for Students

I have come with some questions to help me with this interview, but you can lead me wherever you want to go.

1. Can you please tell me how you came to the decision to become a nurse?
2. Why did you decide to enroll at this school?
3. Please tell me what it was like for you to begin your studies in nursing at this campus
4. What are the things that might encourage you to keep studying in this program?
5. Are you in the Access Program? If so, what aspects of the access program are helpful/not helpful?
6. Can you tell me how you are funded to study nursing?
7. I am interested in your clinical courses. Can you tell me about your clinical placements? What did you learn from it? What was helpful? What wasn't helpful?
8. Tell me about your experience in the classrooms and laboratory practice sessions.
9. What factors (people/situations/past experiences) influenced your ability to participate/not participate in learning how to become a nurse?
10. If there are typical ways of learning how to become a nurse, how do they occur?
Learning new knowledge? Practicing skills? Watching role models?
11. With whom would you usually discuss learning about nursing and how would the conversation flow?
12. Have you had an experience when you felt supported in the learning process? What was this experience like for you? How did you respond?

13. If you thought you needed assistance with a nursing course, who would you approach? Does this school offer tutoring for you?
14. Have you had an experience when you felt a lack of support in the learning process? What was this experience like for you? How did you respond?
15. Do you perceive that the teachers, postsecondary institution, community, government, Canadian government have a particular position about Aboriginal nurses and nursing students? How do you see that influencing your learning process?
16. If you were conducting this study, whom would you approach for information about the social factors that influence the experiences of Aboriginal students?
17. Is there anything else that you would like to tell me about your experience as a nursing student?

Interview Guide - Faculty

I have come with some questions to help me with this interview, but you can lead me wherever you want to go.

1. First of all, how long have you been a nurse educator?
2. Please tell me about your experience teaching ANS.
3. If there are typical ways of teaching a ANS, how do they occur?
4. Have you had an experience where a ANS emulated the “perfect” nursing student? Can you tell me about this situation? What was this experience like for you? How did you respond?
5. Have you had an experience where a ANS emulated the “problem” nursing student? Can you tell me about this situation? What was this experience like for you? How did you respond?
6. What factors diminish your ability in helping ANS learn how to become a nurse?
7. What factors enhance your ability to facilitate learning for ANS?
8. Do you perceive that the school, postsecondary institution, community, and/or government have a position about FNNS being recruited and retained in nursing education? How do you see that influencing the process?
9. If you were conducting this study, who would you interview to gather information about the historical, sociocultural, political, and ideological factors that shape the educational experience of ANS?
10. Is there anything else that you would like to tell me about your experience with ANS?

Interview Guide for Key Informants

11. I have come with some questions to help me with this interview, but you can lead me wherever you want to go. Can you tell me about the history of Aboriginal peoples in education and/or nursing?
12. What factors diminish the ability to recruit and retain Aboriginal Peoples in the nursing profession?
13. What factors enhance the ability to recruit and retain Aboriginal Peoples in the nursing profession?
14. Do you perceive that the postsecondary institutions, provincial or federal health departments, and the community have a position about Aboriginal Peoples being recruited and retained in nursing profession? How do you see that influencing the process?
15. Who else could provide me with information about how the historical, sociocultural, political, and ideological context of nursing education shapes the experiences of ANS?
16. Is there anything else that you would like to tell me about?

Appendix H

Informed Consents

Purpose of the Study:

The purpose of the study is to examine the experiences of Aboriginal nursing students in a school of nursing located in Canada, from both an individual and a larger, social perspective. This study is interested in finding out how social forces shape the experience of Aboriginal nursing students.

The co-investigator is conducting this research project to attain a graduate degree in nursing. The co-investigator will use the findings of the study to formulate recommendations for schools of nursing in Canada. These recommendations will be communicated to key stakeholders (schools of nursing, Assembly of Chiefs, Aboriginal Nurses Association of Canada) by written reports, publications, and oral conference presentations. Future Aboriginal nursing students may benefit from enacted recommendations.

Study Procedures:

You understand that you are being invited to participate in this study because you identify yourself as an Aboriginal person, registered at this particular faculty or school of nursing. If you agree to participate in the study, Ardelle will ask you to make an appointment for a one-hour audio-taped interview at a date and time that are mutually convenient. Ardelle will meet you at a specific location at the school of nursing and accompany you to an interview room. At the beginning of the interview, Ardelle will place a tape recorder on the table or desk. The tape recorder is approximately 6 inches by 3 inches by 1 inch in size, with the microphone located within its box. When you and Ardelle are ready to start the interview, Ardelle will turn on the power of the tape recorder.

During the interview, Ardelle will ask you questions about your experiences as an Aboriginal nursing student. After approximately 1 hour, Ardelle and you will mutually decide to conclude the interview. At that time, Ardelle will turn off the power of the tape recorder. Following the interview, the audiotape of your interview will be transcribed, which means that the words spoken in the interview will be typed and become a document identified by a code such as "Student #1, 2, 3, etc.." Ardelle will document her observations about the interview process in field notes identified by a code such as "FN for Student #1, 2, 3, etc."

Risks:

Your participation in this study may cause you to reflect upon past and present educational experiences and stimulate some emotional distress. If you are a survivor of a **Residential School**, please inform Ardelle **prior** to the interview. If you experience any emotional distress during or following the interview, please notify Ardelle immediately.

Page 2 of 4

CF Version: August 6, 2004

Benefits:

Participation in this study may result in a better understanding of shared and unique experiences of Aboriginal nursing students. You may develop a better understanding of the wider social factors that may influence your experience.

Confidentiality:

Your participation in this study will be kept strictly confidential and known only to Ardelle Kipling. Your interview will be identified only by code number and the hard copy will be kept in a locked filing cabinet in Donna Martin's home office. The computer has a password known only to Donna Martin. You will not be identified by name in any reports of the study. You will be referred to as "Student #1, 2, 3, etc." Identifiable features about you and your stories will not be included in study reports. Data records will be stored on a computer hard disc in Donna Martin's home office with back-up floppy discs in a locked filing cabinet. After 10 years, hard copies of data will be shredded and computer files will be erased. Furthermore, the thesis committee members (Dr. Joan Anderson, Dr. Barbara Paterson, Dr. Carol Jillings, and Dr. Michael Marker) and the advisory council of Aboriginal nurses (Lucy Barney, Dr. Evelyn Voyageur, Marie Jebb, Gertie Merasty, and Indigo Sweetwater) will not be aware of the data's relationship to individual students.

Contact:

You understand that if you have any questions or desire further information with respect to this study, you may contact Dr. Joan Anderson at (604) 822-7455.

Contact for Information about the Rights of Research Subjects:

This research has been approved by the Behavioural Research Ethics Board, University of British Columbia, the Education/Nursing Research Ethics Board, (Name of participating institutions). If you have any concerns or complaints about your participation in this study or rights as a research subject, you may contact the Research Subject Information Line in the UBC Office of Research Services at (604) 822-8598 or the Human Ethics Secretariat at the (name of institution) at (Phone number) or e-mail: (address)

Consent:

Your signature on this form indicates that you have understood to your satisfaction the information regarding participation in the research project and you agree to participate.

In no way does this waive your legal rights nor release the researchers, sponsors, or involved institutions from their legal and professional responsibilities. Your participation in this study is entirely voluntary. You may refuse to participate or withdraw from the study at any time, and/or refrain from answering any questions you prefer to omit, without prejudice, consequence, or jeopardy to your education.

Your signature below indicates that you have received a copy of this consent form for your own records.

Student Signature

Date

Researcher and/or Delegate's Signature

Date

Summary of Findings:

If you would like a summary of the study's findings at the conclusion of this project, please provide your permanent mailing address or a permanent e-mail address below:

The co-investigator is conducting this research project to attain a graduate degree in nursing. The co-investigator will use the findings of the study to formulate recommendations for schools of nursing in Canada. These recommendations will be communicated to key stakeholders (for example: schools of nursing, Assembly of Chiefs, Aboriginal Nurses Association of Canada) by written reports, publications, and oral conference presentations. Future Aboriginal nursing students may benefit from enacted recommendations.

Study Procedures:

You understand that you are being invited to participate in this study because you have previously been or are currently involved in the education of Aboriginal nursing students. You and Donna Martin will schedule a one-hour interview at a time and place that is mutually convenient. At the beginning of the interview, Donna Martin will place a tape recorder on the table or desk. The tape recorder, rectangular in shape, is approximately 6 inches by 3 inches by 1 inch in size, with the microphone located within its box. During the interview, Donna will ask you questions about your experiences teaching/advising Aboriginal nursing students. After approximately 1 hour, Donna and you will mutually decide to conclude the interview. Following the interview, the audiotape of your interview will be transcribed into a document identified by a code such as "Faculty #1, 2, 3, etc." Donna will also document her observations about the interview process in fieldnotes identified by a code such as "FN Faculty #1, 2, 3, etc."

Risks:

Your participation in this study may cause you to reflect upon past and present educational experiences and stimulate some emotional distress.

Benefits:

Participation in this study may result in a better understanding of shared and unique experiences of Aboriginal nursing students. You may develop a better understanding of the wider social factors that may influence Aboriginal nursing students' educational experiences.

Confidentiality:

Your participation in this study will be kept strictly confidential and known only to Donna Martin. You will not be identified by name in any reports of the completed study. You will be referred to as "Faculty #1, 2, 3, etc." Identifiable features about you and your stories will not be included in the study's reports. All hard copies of the documents and back-up floppy discs will be identified only by code number and kept in a locked filing cabinet in Donna Martin's home office.

Page 2 of 4

CF Version: August 6, 2004

Your signature below indicates that you have received a copy of this consent form for your own records.

Faculty Signature

Date

Researcher and/or Delegate's Signature

Date

Summary of Findings:

If you would like a summary of the study's findings at the conclusion of this project, please provide your permanent mailing address or a permanent e-mail address below:

This study is interested in finding out how social forces shape the experience of Aboriginal nursing students in Canada.

The co-investigator is conducting this research project to attain a graduate degree in nursing. The co-investigator will use the findings of the study to formulate recommendations for schools of nursing in Canada. These recommendations will be communicated to key stakeholders (for example: schools of nursing, Assembly of Chiefs, Aboriginal Nurses Association of Canada) by written reports, publications, and oral conference presentations. Future Aboriginal nursing students may benefit from enacted recommendations.

Study Procedures:

You understand that you are being invited to participate in this study because you can offer some information about the factors that shape the education experiences of Aboriginal nursing students. If you agree to participate in the study, Donna Martin will telephone or e-mail you to make an appointment for a 1-hour audio-taped interview at a date and time that are mutually convenient. If you are located outside of Winnipeg, a telephone interview will be scheduled. If you are located in the near proximity of Winnipeg, a face-to-face interview will be conducted. At the beginning of the interview, Donna will place a tape recorder on the table or desk. The tape recorder, rectangular in shape, is approximately 6 inches by 3 inches by 1 inch in size, with the microphone located within its box. During the interview, Donna will ask you questions about your knowledge of the factors that shape the educational experiences of Aboriginal nursing students. Following the interview, the audiotape of your interview will be transcribed word for word. Donna will document her observations about the interview process in field notes.

Risks:

Your participation in this study may cause you to reflect upon the factors that affect the educational experiences of Aboriginal nursing students and stimulate some emotional distress. If you are a survivor of a **Residential School**, please notify Donna.

Benefits:

Participation in this study may result in a better understanding of other social factors that may influence Aboriginal nursing students' experiences in schools of nursing.

Page 2 of 4

CF Version: August 6, 2004

Confidentiality:

Consent:

Your signature on this form indicates that you have understood to your satisfaction the information regarding participation in the research project and you agree to participate. In no way does this waive your legal rights nor release the researchers, sponsors, or involved institutions from their legal and professional responsibilities. Your participation in this study is entirely voluntary. You may refuse to participate or withdraw from the study at any time, and/or refrain from answering any questions you prefer to omit, without prejudice, consequence, or jeopardy to your position.

Your signature below indicates that you have received a copy of this consent form for your own records.

Key Informant Signature

Date

Researcher and/or Delegate's Signature

Date

Summary of Findings:

If you would like a summary of the study's findings at the conclusion of this project, please provide your permanent mailing address or a permanent e-mail address below:
