


## Qualitative Research

# An Opportunity for Healing and Holistic Care

## Exploring the Roles of Health Care Providers Working Within Northern Canadian Aboriginal Communities

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**Purpose:** The purpose of this qualitative study was exploring what the roles and challenges of health care providers working within Northern Canadian Aboriginal communities are and what resources can help support or impede their efforts in working toward addressing health inequities within these communities. **Design:** The qualitative research conducted was influenced by a postcolonial epistemology. The works of theorists Fanon on colonization and racial construction, Kristeva on semiotics and abjection, and Foucault on power/knowledge, governmentality, and biopower were used in providing a theoretical framework. **Methods:** Critical discourse analysis of 25 semistructured interviews with health care providers was used to gain a better understanding of their roles and challenges while working within Northern Canadian Aboriginal communities. **Findings:** Within this research study, three significant findings emerged from the data. First, the Aboriginal person's identity was constructed in relation to the health care provider's role of delivering essential health services. Second, health care providers were not treating the "ill" patient, but rather treating the patient for being "ill." Third, health care providers were treating the Aboriginal person for being "Aboriginal" by separating the patient from his or her identity. The treatment involved reforming the Aboriginal patient from the condition of being "Aboriginal."

**Keywords:** *Aboriginal health; community health nursing; critical discourse analysis; First Nations health; healing; holistic care; Northern nursing practice; qualitative research*

## Introduction

State dependency and the impacts of colonialism influencing the daily lives of Aboriginal persons are known realities across the Canadian health care landscape. However, delving into the discourses of how to reduce health disparities of a colonized population is a sophisticated issue with many factors to consider. Colonial legislation and colonial relations can also be contributing factors to the current health gaps among Aboriginal populations, specific to the negative representation of Aboriginal persons in society. Moreover, exploring present-day history within isolated Northern Canadian Aboriginal com-

munities cannot be examined without the backdrop of colonization and racism (LaRocque, 2010).

Ethics approval for this study was granted by the Research Ethics Board at the University of Ottawa. The aim of this research inquiry was to provide a

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critical analysis that spoke to the humanity and justice of a vulnerable population. In particular, across the Canadian health care landscape, social health issues for Aboriginal persons are well documented within current literature and federal health reports. Yet leading Indigenous scholars stated that the levels of health inequities among Aboriginal persons are a pressing matter that has been ignored for far too long. In general, being complacent about normative health statuses can be considered as a social injustice and travesty for Aboriginal persons. As local and national concerns for health inequities among Aboriginal persons are becoming more prevalent in everyday discourses, there is growing attention on the need to address these grave matters surrounding Aboriginal persons' health. The state of health affairs regarding Aboriginal persons, particularly within First Nations and Métis in rural and remote Northern communities, is gaining national and global interest.

Through a critical analytic approach, the status quo of Aboriginal persons' health was examined to gain a better understanding of how sociopolitical and historical impacts of colonialism played a part in daily discursive practices. Within these communities, the status quo of ill health among Aboriginal persons was maintained to help protect the segregated state between the colonizer and the colonized. Drawing upon this, nurses played a role in maintaining the status quo of ill health among Aboriginal persons within these vulnerable communities. In this research study focusing on nursing the "Other" through a critical theoretic perspective, knowledge was brought forward about what it was like for nurses to work within isolated Northern Canadian communities. Specifically, postcolonial theory was deployed in gaining a better understanding of nurses' roles and challenges in delivering Northern health services and in meeting the communities' health and cultural needs with responsive and relevant care.

## Research Problem

Within Northern Canadian Aboriginal communities, nurses are often the primary health care providers for delivery of essential health services. Within this research study, the study explores the roles of health care providers working within these communities, with the emerging focus on nurses as the primary health service providers. The state of health affairs within Aboriginal populations is relatively

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

Regional health authorities and federal planners have a responsibility within the government's fiduciary obligation to Aboriginal persons to provide health services that meet their health needs in a responsive and respectful way (Boyer, 2004). Nurses are an extension of the state health care system, and they must provide responsive and relevant health services within isolated Canadian Aboriginal communities. However, there remains a lack of consensus about nurses' roles in these Northern health centers, where high expectations, lack of clear directions, and poor documentation burden staff, affecting the outcome effectiveness of care (Swider, 2002). Disaccord about nurses' roles thus adds to the uncertainty of their roles while working within rural Northern and Aboriginal communities.

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

Within rural Aboriginal communities, nurses are usually the sole practitioner providing health care services, and community engagement is difficult for nurses as they often feel like an "outsider" in the community (Tarlier, Browne, & Johnson, 2007). The context of working and residing within isolated

Aboriginal communities can be laden with hardships that make it difficult for nurses to practice (Vukic & Keddy, 2002). Specifically, the challenges of rural nursing include several factors, such as barriers to continuing education, experiences of overwork and burnout, lack of management support and appreciation, large scale of professional responsibility, inadequate schooling and employment for personal family members, poor housing, and poor community amenities (MacMillan, MacMillan, Offord, & Dingle, 1996; Perisis, Brown, & Cass, 2008; Witham, 2000). Additionally, these challenges can also contribute to poor retention of nurses working within rural Aboriginal communities (Assembly of First Nations, 2005; MacMillan et al., 1996; Witham, 2000).

Under these demanding conditions, it can be difficult for nurses to fulfill their roles and responsibilities in providing equitable and effective health care for all, specifically, marginalized populations. Furthermore, it can be difficult for nurses to be effective within their roles without having an understanding of how health inequities within isolated Northern Canadian Aboriginal communities may be related to their various social and historical contexts. Nurses who work within isolated Aboriginal communities are often recruited from outside the community and are generally unprepared for the “culture shock” of working within a foreign community (Gregory, 1992). In these communities, nurses often feel like they are not part of the community, which may contribute to a high turnover of staff. A high turnover rate of nurses along with a shortage of nurses can negatively affect the delivery of consistent and effective health services within rural Northern communities (Lavoie, 2004). These problems are particularly acute at health centers within rural Aboriginal communities, resulting in poor level of quality or complete lack of essential health services (Perisis et al., 2008).

Additionally, stakeholders responsible for providing health services within rural and remote First Nations communities are struggling to retain and recruit nurses within isolated areas. These stressors can contribute to the difficulty in retaining and recruiting rural nurses, often resulting in insufficient and fragmented health services delivery and can further contribute to the lack of hopeful discourse in addressing health inequities within these vulnerable communities. Spanning over the past two

decades, research cited in this section demonstrates that isolated Aboriginal communities have experienced many years of health inequities.

## Research Objectives and Questions

Through a postcolonial epistemic stance, nurses' roles and challenges can be explored in relation to the sociopolitical and historical contexts that have contributed to health inequities, and they can help address these within rural Aboriginal communities. The purpose of the study was to help better understand how nursing roles within an Aboriginal community have been shaped by sociopolitical and historical contexts. The specific research questions were the following:

**Research Question 1:** What are the roles and challenges of nurses working within rural, remote, and Northern Canadian Aboriginal communities?

**Research Question 2:** How can nurses help improve the health of Aboriginal persons within these vulnerable communities?

**Research Question 3:** What are the individual, organizational, and system-level factors that support or impede nurses' work in meeting the community health and cultural needs of Aboriginal persons with respectful and dignified care?

**Research Question 4:** What are the identified areas of knowledge gaps that can help nurses in strengthening pathways for Aboriginal persons' health?

## Literature Review

This section primarily focuses on the challenges of Northern nursing practice including profiles in practice. Generally, there is a level of nursing difficulty that is highlighted by practicing within isolated Northern settings. This can cause additional stress to nursing roles that are otherwise stressful under normal working conditions. Geographical, cultural, and socioeconomic disparities, complexities, and constraints influence the vulnerable health and well-being of Northern populations. Care is structured within biomedical models, further controlling funding, programming, and governance. Nursing prac-

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

Nurses working in rural, remote, Northern Canadian Aboriginal settings are commonly referred to as nurse "generalists" (Bushy, 2002; Leipert & Reutter, 1998; as cited in Tarlier, Johnson, & Whyte, 2003), in that they provide intergenerational care to individuals and families for a variety of conditions, in a variety of contexts. In such isolated settings, the nature of nursing practice is complex and challenging, requiring nurses be competent and responsible in the management of acute and chronic health issues, oftentimes functioning as multispecialists (Canadian Association for Rural & Remote Nursing, 2008; MacLeod, Browne, & Leipert, 1998). For newcomers, rural nursing presents a startling transition process, where flexibility is of necessity if one is to adapt to the social, structural, and cultural context of practice (Tarlier et al., 2003). For instance, limited resources make for increased autonomy, adaptability, creativity, and collaboration (Canadian Association for Rural & Remote Nursing, 2008; Leipert & Reutter, 1998; Tarlier et al., 2003; Vukic & Keddy, 2002). Technological savviness is also an asset given the increased provision of services and consultations via telehealth information systems (Bushy, 2002).

Given the shift from a task-oriented to a community-centered approach to primary health care, nurses learn to build responsive relationships with the communities they serve, for mutual trust, respect, and active engagement have been attributed to positive treatment outcomes (Tarlier et al., 2003). Responsiveness to community strengths, priorities, and activities can also serve to minimize feelings of nurses as "Other" (Vukic & Keddy, 2002). Given the

limited resources, support from and collaboration with schools, police, employment, social services, and the Band office are also common (Leipert & Reutter, 1998). Consequently, the resulting formal and informal networks broaden nurses' access to valuable community information and resources, such as paraprofessionals, traditional healers, and Elders (Bushy, 2002).

Nevertheless, rural nursing practice is multifaceted, harnessing personal and professional characteristics of "resilience, resourcefulness, adaptability and creativity" (Bushy, 2002, p. 109). Difficulties arise, however, when personal and professional expectations are blurred "with little difference between work-home-community" (p. 107). However, this is a natural way of living and working for community health nurses accepting of Indigenous-based cultures. The challenges lie in nurses wanting to accept Indigenous traditions, knowledge, and practices that may not be relevant to them.

## Theoretical Framework

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

Development of nursing knowledge from a postcolonial approach shifts research away from "ahistorical and depolarized models, and toward a more contextualized understanding" (Mohammed, 2006, p. 107) of modern-day issues. The philosophical underpinnings of postcolonialism draw upon multiple disciplines, including philosophy, humanities, cultural studies,

and literacy criticism, and they will be used to discuss the legacy of the colonial past (Anderson & McCann, 2002). Aspects of present-day health care will be explored from a postcolonial perspective to illustrate power dominance as seen within socially constructed concepts, such as racialization, culturalism, and "Othering" (Browne, Smye, & Varcoe, 2005). These concepts may present barriers where socially excluded groups such as "Others" can be further marginalized within the health care system. Understanding health inequities based within social and historical contexts can help transform nursing practice to include all groups of society focusing on "sensitive issues related to race, gender, and class" (Racine, 2003, p. 91). A postcolonial perspective in nursing knowledge development goes beyond alleviating suffering associated with "race-contextualized" thinking by working toward promoting equitable health care services.

The theories offered within this theoretical framework include the racial theory and the racialized "Other" by Frantz Fanon, semiotics and abjection by Julia Kristeva, and governmentality, power/knowledge, and bio-power by Michel Foucault. The key elements that integrated the various theories together is that due to historical and sociopolitical contexts, there is a power relation between the object and subject where the subject is controlled and cared for by governing forces.

Within Fanon's work, it was noted that the subject was identified by a racialized constructed social identity created in a relationship based on the colonizer and colonized. Poignantly, the relationship subjugating the colonized in the consciousness of the colonizer is a crucial element in situating power relations. Through Kristeva's theory of language, meaning created and communicated within language is further solidified within society's values through the power relations of the "subject" and the "object." The subjectified self is alienated and isolated within society without possibilities of change unless there is a call of action upon the objects of power. Adding on with Foucault's theories, postcolonial scholars can deconstruct how power is applied within institutions to control power over life of individuals and communities through care. Foucault's work is applied to social justice by critically analyzing how care is provided by exception without significance.

All of the various theorists including Fanon's, Kristeva's, and Foucault's work can be well interwoven within a larger postcolonial epistemic stance to

address how power imbalances of Aboriginal persons within society are an issue that needs to be addressed today with both significance and immediacy as being part of the human condition. The work of these theorists is credible in offering a theoretical framework for critical researchers and scholars in nursing to probe beyond the given meaning of the inferior, insignificant, and irrelevant. Critical research influenced by postcolonial theory can help analyze how relationships in society have been created and maintained by the power relations that govern individuals and populations.

## Methodological Considerations

### Design: Critical Discourse Analysis

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

### Research Settings and Recruitment

The presentation to recruit potential participants was given on several occasions to employees of the local health region to ensure that nurses and

other health care professionals were aware of the study and had an opportunity to ask questions about participating in the study. Additionally, the principal investigator met with the nursing staff and managers of each department, introduced herself, and provided an overview of the research study. The purpose, methodology, and potential contributions were described to the participants. The purpose of the study was described as to explore how nursing roles might be shaped by social and historical contexts within rural Northern and Aboriginal communities. In addition to the nursing shortage faced by rural communities, conducting research in Northern Saskatchewan created a privileged setting for studying issues that are relevant to nurses working within isolated Northern Canadian communities. Being true to a qualitative study, the research was conducted with participants within their natural setting.

### Data Collection

This research study used primary data sources: interviews with 25 participants, including frontline nurses, physicians, and regional health care administrators working within rural and remote communities in Northern Saskatchewan. The interviews were semiguided with two foci that included participants describing their roles and challenges within their contextual setting, and identifying what organizational resources would be helpful in supporting them throughout their work. Interviews with other health care professionals such as physicians and administrators focused on their observation and analysis of nurses' roles and challenges within the communities, and what resources from their perspective would help nurses in delivering health services with relevant care to the communities.

The interviews were conducted over a period of 1 month. During this time, the participants were found to be forthcoming with their narratives, emotions, and perceptions of events. Specifically, 21 of the interviews were conducted at the local hospital, 2 interviews were conducted at the local primary health care facility, and the remaining 2 interviews were conducted through videoconference at a nursing outpost station in Northern Saskatchewan. Each participant had separate interviews, and interviews ranged from 60 to 90 minutes. All participants, with the exception of one, agreed to be audio-taped, and hand-written notes captured the interview without audio-consent.

### Data Analysis

A key element of CDA is to critically examine the relationship between the "social and the linguistics" within a textually based discourse analysis (Chouliaraki & Fairclough, 1999). Textual data analyses from all of the interviews were analyzed through CDA to explore how nursing practice has been shaped by dominant discourses, and to help better understand the relationship between language and sociopolitical practices. The texts were analyzed at different levels of analysis moving from text's syntax to production to understanding, including the micro-level, meso-level, and macro-level, respectively.

Within Fairclough's approach to CDA, there are three levels involved in textual analysis, in particular the sociocultural level, the discourse practice level, and the textual level (Smith, 2007). Key phases of the textual analysis include a critical analysis of the context in which the text is produced, the textual techniques, and how the text shapes different practices (Crowe, 2005). These elements have also been referred to as analyses at the micro-level (text's syntax), meso-level (production and consumption), and macro-level (intertextual understanding; Smith, 2007; van Dijk, 1992). The different levels of textual analysis are used in developing knowledge to explore how language is a form of social practice rather than an individual activity (Fairclough, 1992). Within this study, the nurses' roles and challenges of working within Northern communities was not viewed as an individual activity, rather as a collective force in caring for their population of interest. In particular, CDA was used to explore how nurses' perceptions of Aboriginal persons played a role within their nursing practice by analyzing the textual data for meanings related to sociopolitical and historical contexts embedded within their daily discourses.

### Results

The method of CDA reaches beyond thematic analysis of qualitative research and moves toward understanding the power balance often represented by societal values through the use of language. Through CDA, five main themes were identified with sub-themes to follow within each theme. The five themes were the following: *Structural Health Care Systems*, *Public Portrayal of "Native" Peoples*, *Public Portrayal of "Native" Communities*, *Colonizing Nursing Practice*,

and *Mobilizing Pathways in Aboriginal Health*. Below, a synthesis of each theme and subtheme is presented. The synthesis of each theme leads to a larger understanding of the roles and challenges of nurses working within rural Northern and Aboriginal communities influenced by a postcolonial stance.

### Structural Health Care Systems

The first theme, Structural Health Care Systems, speaks to the overall structure that nurses are working within, and how these structural systems shape practice on a daily basis. This theme is divided into three categories: *Organizational Culture*, *Carrying Capacity*, and *Administrative Influence*. During the interviews, participants spoke about what motivated them to be a nurse and what led them to working within rural Northern and Aboriginal communities. Participants also spoke about what it is like for them to work in the North, and how some of the structures in place can sometimes create challenges for them in their day-to-day practice. For example, under Organizational Culture, one participant offered that it was difficult to know what to do as lack of structural organization influenced their roles and create challenges within the workplace. As described,

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

In this example, the participant offered that their duties and expectations including providing patient care could be forced upon them. In further analysis, nurses felt less "stuck" in providing patient care if they felt more supported by their organization. The implied meaning was nurses became resentful within their roles and duties without structural support from their workplace.

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

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

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

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

These are some examples that demonstrated working limitations of nurses as they practiced within rural, remote, and Northern settings.

### Public Portrayal of "Native" Peoples

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

views of the mainstream society, First Nations people presented themselves as being “Native,” rather than as a First Nations person. This cultural distinction was important as it played a role in how nurses cared for their clientele and in how their viewpoints can affect their client’s care and health outcomes. Within this section, *Public Portrayal of “Native” People*, the data revealed how nurses and various stakeholders viewed their clientele and communities, as well as how these viewpoints can have an impact on their client’s health and health outcomes.

Throughout practice, the participants’ approach to nursing clinical care was not based on the etiology of the disease, but rather its focus was on the population that had the disease or illness. For example, the perception of being “Native” was treated as an etiology for diseases or a justification of having advanced health conditions in comparison to non-Aboriginal populations. One participant explains,

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

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

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

The act of judging their “Native” clients became a part of nursing care. For example, this participant

was not able to remove his judgment from influencing how he perceived his client.

### **Public Portrayal of “Native” Communities**

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

Under *Interjections*, from this section, some of the examples offered that being “Native” was almost like a condition or a state of poor health affairs. For example, one nurse argued,

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

In general, the participants within this study expressed that they did not have hope for the children, as they were part of a perceived “Native” state of being. In particular, the living conditions that the children were exposed to were subpar to the normal expectations within acceptable limits of societal living. One participant stated,

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

The expression of lack of hope for living a normal, healthy life was extended to other areas of health, including public health, sexual health, and infectious disease. The impression that the nurses had



from working with their clientele was that high sexually transmitted disease rates were part of the condition of being a “Native” person or being from a “Native” community. The focus of care within treatment was centered on the nurses’ roles and duties of caring for the client, rather than focusing on caring for their client or promoting healthy living.

### Colonizing Nursing Practice

Through CDA, it was becoming evident that nurses within the North were in a difficult position of providing Northern health services with limited and, possibly, restricted resources. The community’s health needs were not in accord with the needs of the government’s mandate. Also, nurses were working within an environment where their mandates were unknown and noncommittal. It was also unclear as to where the nurses’ loyalty lay, whether it was to the government or to the community, and it would be difficult to be both. *Colonizing Nursing Practice* presents an uncomfortable position, and yet one which where nurses are expected to assume, as agents of the state, in the suppression of the health of Aboriginal persons. Under this theme, *Public Health Surveillance* was a major theme focusing on mental health addictions, communicable diseases, and noncommunicable diseases.

For example, under mental health addictions, nurses were aware that the extent of the substance abuse and addictions within their communities would not be an easy task to address. As a result, their clients were suffering. As described,

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

From the interviews, the nurses spoke about an underlying darkness that clouded the community with mental health and addictions issues. These issues not only affected their clients but also their families and vice versa. The nurses were aware that the complex health issues of Aboriginal peoples were connected to the social and political consequences

of governmental decisions. However, the nurses were uncertain as to what their roles or influences of power were in addressing these issues.

Another category was communicable diseases within the community. The main communicable diseases that were identified by the participants included sexually transmitted infections (STIs), human immunodeficiency virus, and tuberculosis. Some of the participants described treating STIs as if it were routine, and having no consequence to them as health care workers. For example,

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

Similar to communicable diseases, nurses were also overwhelmed with the high rate of noncommunicable diseases that their communities faced, particularly with diabetes mellitus types 1 and 2. For example,

The biggest health problem in our community is diabetes. Diabetes type 1 and type 2 diabetes are the biggest preventable health problem in our community. (23: 156-162)

The impact of diabetes on the community was stressful and had many implications not only to the individual but also to their family and communities.

### Mobilizing Pathways in Aboriginal Health

From the data analysis, it was becoming apparent that nurses were frustrated with the poor health status of Aboriginal persons and of those within their population of care. Some nurses were trying to understand the reasons why their clients had poor health compared to other areas in the province. Other nurses tended to be defensive about their own positions and actions. During the data analysis, *Reflections* was part of the last theme that emerged from the interviews with self-awareness as a sub-theme. Participants had described their frustration in that with all the varied health issues facing their

communities, they felt hopeless in not being able to know what to do nor how to contribute in a meaningful way to decrease the health inequities. Some of the participants felt that they did not have the expertise to be able to address the health issues that their clients were facing on a daily basis. For example,

Again, limited experience. But, from everyone that I have spoken with and from the attitudes I have gotten from everybody, there is a huge desire to make sure nobody falls through the cracks as much as it is in some people's power to do. (5: 444-448)

I hate feeling that way as a nurse. *I just do not know what to do.* [Emphasis added] It is the worst feeling. It is a huge barrier. (5: 502-503)

There may not be a right or wrong way to providing care for their patients; however, an approach that is inclusive of clients can lead to better population health outcomes, and thus be the more beneficent approach to take. Such an approach can help nurses work toward improving health outcomes for their clients and communities. This section emphasized that the spotlight is not on the poor status of health outcomes for Aboriginal persons but rather on how nurses can help in mobilizing pathways for Aboriginal persons' health.

## Discussion

Within this research study, three significant findings emerged from the data. The first finding of significance as it related to these objectives was that the Aboriginal person's identity was constructed in relation to the nurse's role of delivering essential health services. Specifically, the Aboriginal person was a person in relation to the colonized society, and nurses played a role in governing Aboriginal persons, including First Nations and Métis people for purposes of the state. In this study, Aboriginal persons (the colonized) did not exist without being in a relationship with their nurse (the colonial agent).

Within these Northern communities, the existence of the colonized did not stand alone from their colonizer or agents of their colonizing state. Fanon further adds that the social suffering embedded in the psyche of the colonized speaks to the idea that there is "no memory of struggle in the former slave's consciousness [and hence] the slave *himself* cannot

be certain of his own value" (as cited in Honenberger, 2007, p. 158). Thus said, conditional values of being "Aboriginal" were placed upon the person. In particular, the Aboriginal person did not have autonomy over their health entity, as they were dependent on their colonizer for their existence. From this position, nurses were acting as agents of the state in enforcing the Aboriginal person's identity as being subjugated within a colonized society. Moreover, Aboriginal persons seeking health services did not have autonomy over their health affairs, as they were dependent upon the State for the delivery of health services.

As informed by the research data, the second finding of significance in this research study was that nurses were not treating the "ill" patient, but rather treating the patient for being "ill." Indirectly, participants considered the state of being "Aboriginal" as the focal point for treating illnesses and managing diseases. As a collective group, nurses were concerned by the state of their clients' poor health status. To meet the challenges of day-to-day practice, rural nurses saw their scope of practice expand to work within the primary health care context. For instance, everyday practice may require advanced knowledge and ability in, but not limited to, drug or volume replacement therapy, cardiac arrest, trauma, laboratory results interpretation, emergency deliveries, chest X-rays, and health teaching or counselling (Tarlier et al., 2003; Vukic & Keddy, 2002). Thus, the role of Canadian nurse practitioners today has evolved from outpost nursing pioneers (Tarlier & Browne, 2011), and continually needs to be modernized to meet contemporary health issues.

Though sound primary care skills are integral for safe and effective care, particularly given the scarcity of advanced practice in rural and remote settings, these are not all inclusive. Roles must concurrently reflect community health, public health, and primary care needs for primary health care services to be deemed comprehensive (Tarlier et al., 2003), and to address the social determinants that perpetuate health disparities within these communities (Tarlier & Browne, 2011). These generalizations further assumed that Aboriginal persons had poor health due to determinants of health, which became accepted as a status quo.

Furthermore, being "Aboriginal" was perceived by the nurses to be biogenetically shaped by social deterrents of their client's health environment.

Relevant to nursing care, participants expressed that the poor health status of an Aboriginal person was part of the normative health standard for Aboriginal persons. In this light, nursing care did not focus on preventative health care, but rather on treating illnesses and managing diseases by treating the client for their perceived racial variants. As described by Fanon, racism is not only linked to the meaning given to one's race within society but also to the economic reality where one's race also holds meaning (Kane, 2007).

Similar to the second major finding, the third major finding of this research study included treating the Aboriginal person for being "Aboriginal" by separating the patient from his or her identity. The treatment involved reforming the Aboriginal patient from the condition of being "Aboriginal." For example, nursing care had taken on the role of the modern day missionary of the North. Analysis of the data revealed that participants thought the pathway to Aboriginal persons' health included their patients' ability to conform to colonized ways of living and civility.

Within their roles of working with isolated Northern Canadian communities, nurses wanted their patients to conform to rules that were defined by colonial laws and regulations. Moreover, the Aboriginal person was often not aware of the colonizing rules that were superimposed on them by the state. As suggested by Fanon, (the slave) or the colonized is trapped within his own consciousness, and his self-awareness is formed by the external conditions created within the systems of power (Honenberger, 2007). In this sense, the marginalized population can be further marginalized, as they were expected to conform to rules that they were not aware of, nor did they concur to follow.

## Conclusion

Using Fanon's definition that the "Other" is the opposite of the "White/rich/powerful world," but rather is characterized as the "Black/poor/alienated," creates what becomes known as "compartmentalized" sectors, the results of colonization (Kane, 2007). This act of compartmentalizing can play an integral part to the fragmentation of care. Additionally, indifference to care embedded within socially constructed manifestations can be detrimental to the survivor of the survivors. Understanding where and how indifference can be met with respectful and dig-

nified care can help defragment care. Broadly applied, critical discourse about Aboriginal persons' health within isolated Northern Canadian communities can help nurses designify the meaning behind the shame and silence for those alike in the forefront of society. Notably, self-reflective practice can lend itself for nurses to be aware of the impact that the power of their self has on the "Other," as well as understand the impact that the "Other" has in shaping their individualized self as nurses. Furthermore, identifying resources and supports can help nurses achieve their learning goals with evaluative measures. An integral part of nursing practice was for nurses to feel like they were being supported within their work, endeavoring to be proud of the care that they can provide to Northern and Aboriginal communities.

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