

CARING ABOUT RACISM: EARLY CAREER NURSES' EXPERIENCES WITH
ABORIGINAL CULTURAL SAFETY

by

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ABSTRACT

The Aboriginal population in Canada is the youngest and most rapidly growing demographic in the country, and more than half of the 1.4 million Aboriginal people in Canada live in urban centres (Aboriginal Affairs and Northern Development Canada, 2013). As a result, all nurses can expect to provide nursing care to Aboriginal peoples during the course of their work, regardless of the setting of their employment. Since the beginning of the new millennium, however, Canadian researchers have documented that Aboriginal people encounter racism and discrimination at the hands of health professionals when they access health care in this country.

In an effort to address this racism and improve the experience of Aboriginal peoples in health care, the Canadian Association of Schools of Nursing (2013) now recommends that undergraduate nursing students receive cultural safety education during their nursing programs. This recommendation is significant because cultural safety differs in important ways from cultural competence, the dominant model of attending to cultural differences practiced by health professionals in North America. The purpose of this study was to examine the experiences of early career nurses translating knowledge of cultural safety into nursing practice.

This qualitative research study used Adele Clarke's (2005) Situational Analysis to interrogate the complex forces and colonial discourses that influence the practice of nurses with Aboriginal people in contemporary health care environments. Thirteen early career nurses and seven experienced northern nurses were interviewed as part of this study, and results showed that for these nurses, a culturally safe approach is one where respect and relationship are centred. The nurses' narratives also revealed that health care professionals make use of discriminatory labels to withhold and delay care for Aboriginal patients, and that intervening on behalf of patients can provoke strong opposition from nursing colleagues in some settings. However, findings also suggest that cultural safety education can help early career nurses to resist and disrupt pervasive colonial discourses in the health care arena. Further, bearing witness to the suffering created by colonialism also informs the nurses' motivation to work as allies with Aboriginal peoples, revealing the link between cultural safety and reconciliation.

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CHAPTER 1

INTRODUCTION

In Canada, the experience of Aboriginal people in mainstream health care is largely a negative one, influenced, in the main, by the racism and discrimination of health care providers. In order to address racism and improve the experience of Aboriginal people in health care, national nursing and health organizations have, in the last five years, started to recommend that undergraduate nursing students receive cultural safety education during their nursing programs. This thesis explores the topic of racism and discrimination toward Aboriginal people in health care from the perspectives of early career nurses. Specifically, I explore how nurses use the concept of cultural safety to navigate racism and advocate for their Aboriginal patients in their nursing practice.

This first chapter will begin with a discussion of the problem statement, followed by the research questions used to guide this inquiry. I then explain my personal location and the terminology used in this document. I close the chapter by outlining the organization of this thesis.

Statement of Problem

It has been well documented that Aboriginal people experience discrimination and racism in the Canadian health care system (Allan & Smylie, 2015; Arnold, Appleby & Heaton, 2008; Browne & Fiske, 2001; Browne, 2007; Health Council of Canada, 2012; Tang & Browne, 2008). It has also been recognized that Aboriginal people will not access a health care system when they do not feel safe doing so, or feel at risk for cultural

harm (Aboriginal Nurses Association of Canada [ANAC], 2009b; Health Council of Canada, 2012). In response, the Health Council of Canada (2012), ANAC, (2009b) and the Canadian Association of Schools of Nursing (CASN, 2013) recommend that undergraduate nursing students receive Aboriginal cultural safety education during their nursing programs.

Cultural safety was developed in Aotearoa New Zealand in the 1980s by Maori nurse leaders, in response to their peoples' dissatisfaction with nursing care and poor recruitment and retention of Maori students in nursing programs (Nursing Council of New Zealand [NCNZ], 2013; Ramsden, 2002). The model of cultural safety was introduced into the Canadian context by Reimer-Kirkham and colleagues (2002), and the two aims of cultural safety—to influence change in nursing practice and address the shortfall of Aboriginal nurses—have both been recognized as having important implications for nursing education, practice and research in this country (ANAC, 2009a,b; Browne, Smye & Varcoe, 2005). In this chapter I will introduce my thesis research in which I explored the practice experience of early career nurses with cultural safety.

Research Questions

My research question, “What are the experiences of early career nurses using cultural safety in their nursing practice with Aboriginal peoples?” has been informed by several years experience as a nurse educator with undergraduate nursing students, integrating cultural safety education into two undergraduate nursing courses, close

involvement with a local cultural safety initiative and many years experience working as a nurse in Aboriginal communities before becoming a nurse educator.

The title for this thesis was inspired by one of my students who shared that although the nurses she had worked with in a small northern community made racist comments about their Aboriginal patients, they really did *care*: I was struck immediately by the question, “How might nurses care without racism?” In conversations with nursing students during their practicums in both urban and rural settings, my students have shared their struggle with nurses’ differential treatment and racism toward Aboriginal people.

Although Schick and St. Denis (2003) report that their preservice education students express resistance toward the compulsory cross-cultural education course that they teach, most of the nursing students that I have worked with are shocked, disappointed and silenced by the racism expressed by their nursing colleagues in practice settings: it is my impression that they want to practice with nurses who engage in culturally safe practice with their Aboriginal patients, who are reflective about their interactions, and provide leadership in this regard in the clinical setting. Besides the paucity of culturally safe role models for early career nurses in Canadian work environments, nursing students have shared with me their feelings of complicity when they remain silent witnesses of racism in the work place. However, if nurses are to challenge the racism that they encounter in their practice environments, a key question for nursing students and nursing educators is, “How?” The research of Jeffery and Nelson (2009) in social work education is suggestive of my experience with nursing students: I have discovered that with increased knowledge and awareness of racism, my students don’t know how to effectively challenge racism in their work environments. As a

doctoral student and a nurse educator, I see these issues as pointing to the importance of examining the experiences of nurses with cultural safety in practice.

The overarching goal or guiding question that I explore in my study is, “How do early career nurses productively challenge racism toward Aboriginal peoples in their practice settings?” Other questions include: What practices do early career nurses engage in around Aboriginal people? What behaviors and institutional policies are barriers to culturally safe practice? What is supportive of culturally safe practice in contemporary health care environments? What strategies do early career nurses consider successful in promoting cultural safety? And, What are the implications of these findings for nurse educators? Pedagogy is consequently an important dimension of my study as well, and during my research I also questioned participants regarding their most meaningful educational experiences in their learning journey with cultural safety.

Personal Location

Many Aboriginal and non-Aboriginal scholars are urging non-Aboriginal people to take responsibility for the work of decolonization in Canada (Cannon, 2012; Schick & St. Denis, 2003; Regan, 2010). As a white, middle-class woman and nurse educator at a Canadian university, I recognize that I am working and writing from a position of privilege. I share the belief that it is important for educators to participate with their students to unlearn racism (Cochrane-Smith, 2000; Hassounah, 2006), and in the Canadian context, that it is the responsibility of all non-Aboriginal people to learn about the history of colonialism in Canada and reflect on their relationship with this history in the present (Cannon, 2012; St. Denis, 2011). As a nurse educator, I strive to work as an

ally in the Aboriginal community, and I believe that my students need to hear the stories of nurses who are working as allies with Aboriginal peoples in the health care system. I approach the subject matter of this research with this sense of responsibility.

Terminology

In this thesis I will use the term ‘Aboriginal’ to refer to the members of three distinct cultural groups of Aboriginal peoples as recognized in the Canadian Constitution: First Nations, Métis and Inuit (Assembly of First Nations, n.d.). I use the phrase ‘Aboriginal peoples’ out of respect for the diversity of cultures not represented in the singular term ‘Aboriginal.’ The term Indigenous is encountered in global and international literature, and since this term is becoming more common in the Canadian literature, I will use the term Aboriginal to signal the Canadian context. I also use the phrase ‘Aboriginal community’ to refer to small, rural villages of Aboriginal people (living on or off reserve), as well as the more diffuse communities of Aboriginal people in urban centres.

The term ‘Western’ is used to refer to the culture of western European people and their descendants. The Western worldview has become the dominant worldview, and I will use the term to refer to the dominant Eurocentric and colonial governments of western Europe, Canada, the US, New Zealand and Australia, as well as the health care provided in these contexts. I have capitalized the term not to stress its importance, but to distinguish between the word ‘western’ which is used to refer to geographical regions in Canada.

In nursing the word ‘patient’ is used to identify recipients of service in the hospital context; the word ‘client’ is used to identify health care consumers in community or home care settings, to signal the more collaborative relationship that is the foundation of community-based service (Stamler & Yiu, 2008). My use of these terms in this thesis will reflect this distinction.

Organization of the Thesis

In this chapter I have introduced the research, and in Chapter 2 I present a review of the literature. In Chapter 3 I describe the theoretical underpinnings of my study, my choice of Grounded Theory Methods and Situational Analysis (SA) as the method and methodology for my study. In Chapter 3 I also introduce my participants, recruitment strategy, data collection process and how I used SA to analyze my data. Chapters 4, 5 and 6 are my data chapters. In Chapter 4 I explain how the nurses in my study construct cultural safety, and how their practice experiences as nurses have influenced this construction. Chapter 5 describes the participants’ experiences witnessing racism toward Aboriginal patients and clients in contemporary health care environments, and how dominant discourses have influenced what they witness and how they process these experiences. Chapter 6, the final data chapter, explores how nurses navigate the barriers to cultural safety in practice, the dimensions of work environments that support culturally safe practice, and experiences in higher education that have influenced the nurses’ abilities to challenge racism at work. In Chapter 7 I summarize the significant findings of this research in the context of the current scholarly literature, reflect on the significance

of this research for my development as a scholar and nurse educator, and provide some suggestions for future inquiry.

CHAPTER TWO

A REVIEW AND CRITIQUE OF THE LITERATURE

Introduction

In this chapter, I have centred the cultural safety literature in nursing as the key body of literature among other areas of the scholarly literature that connect with cultural safety and the practice of new nurses. I will begin with a discussion of the historical development of cultural safety in Aotearoa New Zealand, and then describe the introduction and development of the concept in the Canadian nursing community. Given that cultural safety involves learning about colonialism and critical self-reflection, I then move to a discussion of Eurocentrism and colonial discourses, focusing on the influence that these discourses can have on nursing practice. As I will elaborate in Chapter 3, Foucault theorized that discourses are “taken up” and become part of identities, including professional identities. As Clarke (2005) has argued, we are “awash in seas of discourses” (p. 145), as discourses are in and around everything we study, created by and significant for everything we study. These discourses interact with each other and produce contemporary effects, in continually changing ways, resonating strongly with the postmodern understanding that discourses have social power (Clarke 2005, p. 149 - 151). Thus we cannot ignore how discourses shape people, their interactions with their social world and their interpretation of it (Clarke, 2005). This discussion will highlight the stereotypes and oppressive attitudes towards Aboriginal peoples that are embedded in popular and health care discourses, and the powerful influence that these discourses exert on how nurses think and talk and act in the Canadian context. In illustrating the multiplicity of discourses and their complex relationships with nursing, my intention here

is to also bring attention to the sophistication of cultural safety, as well as the challenges and importance of bringing cultural safety into nursing education. At the end of this chapter I draw on the higher education literature to shed light on the teaching and learning of cultural safety, and then explore cultural safety in the context of the school-to-work transition literature, for insight on the practice of early career nurses.

Cultural Safety, an Aotearoan Concept

I begin with a review of the historical development and experience with cultural safety in Aotearoa New Zealand, followed by its introduction to Canada, including a comparison with cultural competence, the dominant approach to working with difference in health care in North America.¹ Articles from my initial search were chosen purposively for their ability to provide context for the historical development of cultural safety and to inform the review of the literature. Fifty-four articles met the inclusion criteria, including 17 from Aotearoa New Zealand, 25 articles from Canada, nine from Australia and three from the USA. In my review, I found the papers from Aotearoa New Zealand and Canada to be the most informative, as these two countries have engaged with the topic in more depth, in both practice and research.

The concept of cultural safety emerged from the unique cultural, social, political and historical context of Aotearoa New Zealand in the 1980s and 1990s (O'Connor, 2012; Papps & Ramsden, 1996; Polaschek, 1998). During the early 1980s, the nursing workforce raised concerns over the poor recruitment and retention of Maori students in

¹ To analyze the concept of cultural safety, an online search was conducted for relevant articles in the academic literature. CINAHL, Scopus and Summon were searched for articles containing the phrase “cultural safety.” To narrow the search, additional keywords were used: Aboriginal, First Nations, and Indigenous. Nursing-related literature was searched using the word “nurs*” to capture alternative endings. No year limit was placed on the search, and reference lists were further reviewed to identify additional relevant articles.

nursing programs, the poor health status of Maori peoples and the community's negative experience with mainstream health services (O'Connor, 2012; Papps & Ramsden, 1996). Irihapeti Ramsden, a Maori nurse educator who is widely considered the architect of cultural safety, was hired in 1987 as a nurse advisor to the Department of Education to help develop guidelines for nursing curricula in the country (Nursing Council of New Zealand [NCNZ], 2013; Papps & Ramsden, 1996). Over the next few years, Ramsden organized several public gatherings to consult with the Maori community regarding what was needed to improve Maori health and increase Maori enrollment in nursing programs; to reach these goals, the Maori community identified that health care providers, students and educators needed to learn about colonialism, its impact on the Maori people, and critically reflect on their own culture, values, beliefs and bias; in the Maori language, this is *Kawa Whakaruruhau*, and it is this Maori term that translates into "cultural safety" (NCNZ, 2013; Papps & Ramsden, 1996). The Maori community then chose a group of Maori nurse leaders, led by Ramsden, to develop a set of cultural safety standards and guidelines for the Nursing Council (Wepa, 2003). In 1991, Ramsden submitted a set of guidelines to the NCNZ; they were approved and adopted by the Council the following year (NCNZ, 2011, 2013; Ramsden, 1992). The Council moved quickly, and in 1992, the first set of cultural safety guidelines were made compulsory in nursing education, and cultural safety comprised twenty percent of exam questions on the national nursing registration exam (NCNZ, 2011; Papps & Ramsden, 1996). As Linda Tuhiwai Smith (1999) has argued, Indigenous peoples in colonized spaces have experienced a long history of exclusion from policies and practices that affect their communities, and Indigenous politics of self-determination are about pursuing meaningful participation and

control (p. 39). The development of cultural safety in Aotearoa New Zealand is one such example of the Maori community's pursuit of self-determination in health care.

The words "culture" and "safety" carry many meanings, and it is important to deconstruct the term "cultural safety" to shed light on the intended meanings (Papps & Ramsden, 1996). The word culture as it is used in the term cultural safety reflects a Maori understanding of culture, a robust conception including worldview, ways of living in the world, relationships with others, as well as attitudes and beliefs (Papps & Ramsden, 1996). The term "safety" reflects the meaning of safety used in the health care context, to refer to safe or competent nursing practice, combined with a holistic definition of health, and thereby linking the notion of protection from harm/reduction of risk with a holistic regard for the person or community (Papps & Ramsden, 1996). The working definition of cultural safety adopted at that time by NCNZ was "The effective nursing of a person or family from another culture by a nurse who has undertaken a process of reflection on his/her own cultural identity and recognizes the impact of the nurses' culture on nursing practice" (NCNZ, 1992, p. 7). Culturally unsafe practice was defined in 1992 as "any action, which diminishes, demeans or disempowers the cultural identity and well being of an individual" (NCNZ, 1992, p. 7). As stated above, cultural safety refers to what the Maori community identified as what was needed to improve Maori health and increase Maori enrollment in nursing programs; as such, it is comprised of a parallel set of recommendations directed at the education of nurses on the one hand, and a framework for nursing schools on the other, to guide the recruitment and retention of Maori students.

A primary focus of my thesis is cultural safety education, and the education of nurses and nursing students, which involves learning about colonialism and critical self-

reflection. In her doctoral thesis, Ramsden (2002) conceived of cultural safety as the ultimate goal on a knowledge and learning continuum that progresses from cultural awareness to cultural safety, where cultural awareness is the first step toward an understanding of difference and cultural sensitivity is the next step whereby students begin a process of self-exploration. Ramsden (2002) also stressed that it is the client who determines if the care received is culturally safe, not the provider. As a result, cultural safety is not only a learning process but also an outcome of nursing education, one that enables safe service to be defined by those who receive the service; in doing so, cultural safety is meant to transfer power from the service provider to recipient, and level the longstanding difference in power between providers and patients (Ramsden, 2002). Given that learning about colonialism and its impact on the Maori people is a core tenet of cultural safety, cultural safety education also links the poor health of Aboriginal peoples directly with colonization and cultural assimilation.

This recognition of colonialism and existing power imbalances between recipients and nurses challenged prevailing practices of power in health care and broader society in Aotearoa New Zealand, and in the four-year period from 1992 to 1996, following the NCNZ's adoption of cultural safety guidelines and their compulsory integration into nursing curricula and examination, cultural safety became the subject of widespread negative publicity (Gibbs, 2005; NCNZ, 2013; Papps & Ramsden, 1996; Ramsden, 2002). Challenges from students and instructors went public and fuelled negative press and misinformation: In one highly publicized case, a student who failed the cultural safety component of her nursing exam sent a letter to a national newspaper; in another, a nursing instructor who disagreed with cultural safety as a compulsory component of

nursing curricula was fired (NCNZ, 2013; Ramsden & Spoonley, 1994). In yet another widely publicized case, a student voiced her discontent regarding having to learn about colonialism in nursing school at a political convention (NCNZ, 2013; Ramsden & Spoonley, 1994). In the popular press, cultural safety in nursing education was described as irrelevant, political correctness, social engineering and a challenge to free society; cultural safety was also critiqued as giving unfair attention to Maori; other sources described the teaching of cultural education, power and racism to be at the expense of nursing skills and a potential threat to standards in health care (NCNZ, 2013; Ramsden & Spoonley, 1994; Richardson & Carryer, 2005). Ramsden and other nurse educators attempted to respond to and correct the misinformation, but the groundswell of negative press culminated in the establishment of a parliamentary inquiry in 1995, which demanded a review of the cultural safety component in nursing education (NCNZ, 2013; Papps & Ramsden, 1996; Richardson & Carryer, 2005). The NCNZ established its own independent committee of the cultural safety guidelines, and was able to have the Parliamentary Inquiry suspended later that same year (NCNZ, 2013).

A revised set of guidelines was adopted in 1996, and over the past 20 years, the NCNZ has made several changes to their cultural safety guidelines in response to recommendations from internal reviews, public and scholarly critique and feedback from nurse educators (NCNZ, 2013). The most notable change in the revised 1996 guidelines was the expanded definition of cultural safety so that it could be applied to multiple groups (Richardson & Carryer, 2005; Woods, 2010). While some authors in Aotearoa New Zealand have welcomed this change (DeSouza, 2008; McEldowney & Connor, 2011; Woods, 2010), others have questioned the applicability of cultural safety to a

multicultural context (Gibbs, 2005; Polaschek, 1998; Richardson & Carryer, 2005).

Polaschek (1998) provides the critique that stretching the definition to include other categories of difference and identity decreases the power of cultural safety to address the unique issues faced by Indigenous peoples in health care. Woods (2010), however, argues that the social and ethical dimensions of cultural safety can be combined into a model for nursing that is relevant in a global and multicultural context.

Adoption of Cultural Safety in Canada

In the Canadian context, two nurse researchers from the University of Northern British Columbia (Browne & Fiske, 2001) referred briefly to cultural safety in a publication regarding their study in which they explored First Nations women's experiences with health care. In this paper they suggest that cultural safety could provide nurse researchers, educators and providers with a productive and critical frame to examine racism and discriminatory practices in health care (Browne & Fiske, 2001). Not long after, cultural safety made its first explicit appearance in the Canadian literature in 2002 and 2003, in two publications regarding a study conducted by a group of nurse researchers in western Canada (Anderson et al., 2003; Reimer-Kirkham et al., 2002). In the paper authored by Anderson and colleagues (2003), the authors introduce the concept of cultural safety to the nursing community in Canada and situate it in the field of postcolonial scholarship. For Anderson and colleagues (2003), the purpose of postcolonial theory is to expose colonizing practices that have centred European people and values, and subordinated non-European people as deficient and inferior. Given that cultural safety directs nurses and nursing students to learn about colonialism and engage

in critical self-reflection, it was clear that cultural safety provided a path for taking on the postcolonial challenge in nursing and health care.

As a nurse, my first introduction to cultural safety came in 2005 at a small regional nursing conference with colleagues who were all working with First Nations organizations in rural Aboriginal communities in western Canada. At this conference, an Aboriginal colleague presented the findings of her research in which she had centred the model of cultural safety and the integration of Indigenous knowledges and healing practices for culturally safe care. Her presentation style was also memorable; in contrast with the linear presentations that are common in professional, biomedical contexts, she took us on a circular journey as she shared the story of her research experience, effortlessly bringing us back to our starting point as she closed the circle. Reflecting on this experience now, I am struck by the realization that this experience was part of a growing movement in the field of Aboriginal health in Canada, for within a few years cultural safety was recognized as a critical cultural perspective in the nursing literature and well suited to health care with Aboriginal peoples (Browne & Varcoe, 2006; Gustafson, 2005). Since that time, the Aboriginal focus of cultural safety has been largely maintained in Canadian scholarship (Brascoupé & Waters, 2009; Browne et al., 2009; Rowan, et al., 2013) and postcolonial theory continues to be acknowledged as the theoretical framework that underpins it (ANAC, 2009b; Browne, Smye & Varcoe, 2005). Furthermore, addressing the shortfall of Aboriginal nurses in Canada, as well as the persistent inequities and racism in health care experienced by the Aboriginal population, both remain the key goals for integrating cultural safety into nursing education programs in Canada (CASN, 2013; Rowan et al., 2013).

Before proceeding further into the discussion of cultural safety, it is important to introduce and critique cultural competence in more depth, the dominant model of attending to cultural difference that is used in nursing and health care in North America (Brascoupé & Waters, 2009; Gustafson, 2005; NAHO, 2006). This model was originally called transcultural nursing, and was developed by the American nurse anthropologist, Madeleine Leininger, in 1978 (Leininger, 1978; National Aboriginal Health Association [NAHO], 2006). Leininger developed the model to provide nurses with the in-depth anthropological knowledge of other cultures they needed to provide culturally competent care (Leininger, 1978; 2002). Leininger defined the discipline of transcultural nursing as “the humanistic and scientific study of all people from different cultures in the world with thought to the ways the nurse can assist people with their daily health and living needs” (Leininger, 1978, p. 8). Since that time, this approach has become the dominant model used in Canada and the United States, and the term “transcultural nursing” has given way to the term “cultural competence” in health care parlance (Brascoupé & Waters, 2009; Gustafson, 2005).

Advocates of cultural safety often refer to cultural competence directly or indirectly to contrast its differences with cultural safety (NCNZ, 2011; Papps & Ramsden, 1996; Polaschek, 1998; Richardson, 2010; Woods, 2010). For example, transcultural nursing and cultural competence theories assume that nurses can provide high quality care to cultural others when they learn about the health practices, customs and beliefs of other cultures; some authors in the education, social work and nursing fields have called this culture-based understanding of difference “culturalism,” “culture theory” or a “culturalist” approach (Brascoupé & Waters, 2009; Jeffery & Nelson, 2009;

St. Denis, 2011; Woods, 2010). Influenced by anthropology, this approach focuses on what is different and unique about non-European peoples, and then conceptualizes those differences as static and incommensurate (Joseph, Reddy & Searle-Chatterjee, 1990; St. Denis, 2011). This approach also flattens within-group differences, erasing the rich diversity of Aboriginal peoples and cultures (ANAC, 2009b). Transcultural nursing texts often centre the perspective of the white European nurse, with the unstated assumption that what is different is what is not white (Gustafson, 2005; Papps & Ramsden, 1996). In direct contrast to transcultural nursing, the NCNZ document states explicitly that the purpose of cultural safety in nursing education is to go beyond the learning of rituals, customs and practices, because this approach is overly simplistic and ignorant of the complexity of human behavior and within-group differences (NCNZ, 2011). In the Canadian context, critical nursing scholars widely acknowledge that cultural safety extends beyond cultural awareness, sensitivity and skills-based competencies and is predicated on understanding the racism and power differentials inherent in health care service delivery (ANAC, 2009a; Anderson et al., 2003; Browne et al., 2009; Rowan et al., 2013). Other critiques of transcultural nursing from both Canada and Aotearoa New Zealand include that it focuses on individual interactions without considering the social and historical context (ANAC, 2009a; Polaschek, 1998); that it takes an objective view of interactions between nurses and patients; and ignores power relations and racism in health care (Gustafson, 2005; Polaschek, 1998).

In the years following its introduction in Canada, cultural safety was officially acknowledged by some of our national health and nursing organizations. The National Aboriginal Health Organization (NAHO) in Canada, for example, released two fact

sheets on cultural safety, highlighting that cultural safety draws attention to colonialism, unequal power in health care interactions, discriminatory practices in health care and their impact on the health of Aboriginal peoples (NAHO, 2006, 2009). The first fact sheet highlighted that bringing cultural safety into Canada's health care system would require the inclusion of Aboriginal stakeholders in decision-making processes (NAHO, 2006). Of interest, the second fact sheet highlights the benefits of a culturally safe approach for health care providers, as increased effectiveness meeting peoples' needs contributes to job satisfaction, which, they argue, could potentially improve the retention of providers in communities (NAHO, 2009). In 2009, the Aboriginal Nurses Association of Canada (ANAC), released two cultural safety documents with the Canadian Nurses Association (CNA) and the Canadian Association of Schools of Nursing (CASN): a literature review focused on how to increase the proportion of Aboriginal nurses in the profession by integrating cultural safety into nursing education (2009a), and a framework for this integration (2009b), to serve both Aboriginal patients/clients in health care and Aboriginal students in nursing education. These are two very important documents in the Canadian context, first because they officially position cultural safety as an appropriate model to guide nursing practice with Aboriginal people in Canada, and second, because they are endorsed by CNA and CASN. The ANAC (2009a) literature review identifies that all nursing students, both Aboriginal and non-Aboriginal, need to understand the following to provide quality care for Aboriginal people: colonization, health disparities (including social determinants, protective factors, the role of Elders and traditional teachings), health inequities precipitated by colonialism, the acknowledgement that basic human rights have been unreachable for Aboriginal people, the diversity and uniqueness

of Aboriginal peoples, and recognition of intergenerational trauma, historic trauma transmission and the resilience of Aboriginal peoples to heal.

Since the release of the ANAC documents, the integration of cultural competence and cultural safety concepts into undergraduate nursing curricula in Canada continues to be marked by a considerable variation in implementation (Rowan et al., 2013). For example, in their mixed methods study of Anglophone schools of nursing in Canada, Rowan and colleagues (2013) found that 89% of respondents reported the incorporation of both cultural competence and cultural safety. Rowan and colleagues also note that Canadian schools are influenced by the American context, where cultural competence is integrated, and cultural safety is excluded. However, now that cultural safety is just over a decade old in Canada, more reports have been released that show support for cultural safety as a tool to address health inequities, racism and Aboriginal inclusion in health care (Allan & Smylie, 2015; CASN, 2013; CNA, 2010; Health Council of Canada, 2012).

Canadian authors have affirmed that cultural safety, at its core, is about healing and building relationships (ANAC, 2009a; Brascoupé & Waters, 2009; Van Herk, Smith & Tedford Gold, 2012). ANAC (2009a) places emphasis on this dimension of cultural safety, noting that the harms of colonization happened in the relationship between Aboriginal and non-Aboriginal people. Given the fundamental differences between Western and Indigenous views of health and the colonial disregard for Indigenous knowledges and healing practices in healthcare (Archibald, 2006) it is essential that nurses' communication and interactions with their Aboriginal patients and clients be informed and guided by respect for Aboriginal peoples and worldviews; indeed, respect and communication have been identified as core dimensions of cultural safety and ethical

relationships with Aboriginal peoples (ANAC, 2009b; Hole et al., 2015). Research in Canada and Australia has also identified that communication is fundamental to patients' experience of cultural safety in health care, especially with hearing of the communication of their needs by health care providers (Anderson et al., 2003; Johnstone & Kanitsaki, 2010). Respect in relationships is demonstrated through listening, providing meaningful opportunities for participation, leveling power differences between providers and clients, and using a collaborative approach in which clients take the lead (ANAC, 2009b; RNAO, 2010). Respect also guides Indigenous understandings of relationships, and includes the following relational attributes—listening intently, kindness, courtesy and considering the well being of others (Wilson, 2008).

Given the acknowledgement of trauma created by colonialism, the importance of incorporating a trauma-informed approach in health services provided to Aboriginal peoples is also gaining increased recognition in Canada (Haskell & Randall, 2009; Menzies, 2012). Given that health care in Canada has been created by a colonial system, it has also been recognized that hospital and health care practices are often triggers for institutional trauma, which mimic and reinforce residential school trauma and social discrimination (Hole et al., 2015). Trauma-informed practice (TIP) developed in the addiction and mental health field following the acknowledgment that trauma was very common for people with mental illness and addiction (Canadian Centre on Substance Abuse [CCSA], 2014). The four principles of TIP are trauma awareness, an emphasis on safety and trustworthiness, providing opportunities for choice, collaboration and connection, and the use of a strengths-based and skill-building approach (BC Centre for Excellence in Women's Health [BCCEWH], 2013; CCSA, 2014). To ensure that

patients/clients have a safe experience when they access services, it is essential that trauma awareness is integrated on an organizational level and embraced by all levels of staff (BCCEWH, 2013; CCSA, 2014). Choice, collaboration and connection are reflected in services when providers work to protect clients' dignity, withhold judgment and provide treatment choices (BCCEWH, 2013; CCSA, 2014). Of interest, using a collaborative approach is also considered best practice for nurses supporting clients in self-management of chronic conditions (RNAO, 2010). The postcolonial understanding of cultural safety can inform TIP, and together they provide an appropriate framework for working with Aboriginal peoples. Recently, two nurses in Vancouver have published an article in which they argue for the integration of cultural safety and TIP when working with Aboriginal patients, based on their experiences working with Aboriginal people in HIV care (McCall & Lauridsen-Hoegh, 2014).

Many authors in both Aotearoa New Zealand and Canada have brought attention to the impact of the environment on providers' abilities to practice cultural safety, and the importance of understanding the context that supports culturally safe practice (Anderson et al., 2003; Gibbs, 2005; Polaschek, 1998; Richardson, 2010; 2011; Wood & Schwass, 1993; Van Herk et al., 2012; Woods, 2010). Richardson (2010; 2011), for example, used Bourdieu's concept of relational networks of power to explore how nurses in different work environments make use of their personal, professional and institutional relationships to support or hinder the provision of culturally safe care. Taking this argument further, some Canadian authors have argued that cultural safety needs to be integrated into other sectors, including housing, social work, education and justice, in

order to promote a truly holistic conception of Aboriginal health (Brascoupé & Waters, 2009; Christensen, 2016).

Colonial Knowledge Construction, Epistemological Racism and Health Care in Canada

As discussed in the previous sections, Ramsden's original vision of cultural safety in nursing education included two main elements: learning about colonialism and its impact on the Maori people, and self-reflection on attitudes and assumptions (Papps & Ramsden, 1996). In Canada, as in Aotearoa New Zealand, public education systems have largely omitted the study of colonialism in history curricula, and as a result, nurses and nursing students in both countries are often ignorant of colonial history (McGibbon & Etowa, 2009; Ramsden, 2002). Cultural safety education thus targets this gap in knowledge. Many Canadian scholars position racism at the heart of colonialism in Canada (Cannon & Sunseri, 2011; Dei & Calliste, 2000; Furniss, 1999; McGibbon & Etowa, 2009; St. Denis, 2011), and when racism is acknowledged in this way, it becomes visible that when nurse educators set about to integrate cultural safety education into their curricula and teach students about colonialism, they will be, in fact, exposing racism and practices of oppression and privilege.

Racism is known to operate at different levels: individual, systemic and epistemic (Allan & Smylie, 2015). Epistemic racism in health care includes positioning biomedicine as superior and dominant (Scheurich & Young, 1997), as well as regarding Indigenous Knowledges and healing practices as inferior; systemic racism is about policies, such as the Indian Act and the residential school system, that continue to heap

an unfair burden of poor health on Aboriginal peoples (Allan & Smylie, 2015).

Furthermore, racism at the epistemic and systemic levels is enacted in interpersonal relationships and racism at this individual level can be overt or covert (Allan & Smylie, 2015; Scheurich & Young, 1997). Racism toward Aboriginal peoples is continually reinforced by a colonial ideology that in turn is based on a constellation of Eurocentric assumptions.

Two Eurocentric traditions, one a method and the other a discipline, that have had an enduring influence on the values of Western society and dominant understandings of culture and health, are positivism and anthropology. Positivist philosophy was coined by August Comte in the 1820s, but grew out of ideas that had emerged during the Enlightenment period in Western Europe in the 18th century, (Halfpenny, 1982). These ideas include the assumption that empiricism (knowledge obtained through the scientific method of systematic experiment and observation) is superior to all other methods of knowledge construction, that progress comes from the development of scientific knowledge, that progress is necessary and desirable, and that scientific societies are the most advanced societies (Halfpenny, 1982). If science is presumed to be the most desirable and valuable knowledge, then immediately visible is the hierarchy of knowledges and societies at the heart of Eurocentrism, with European society assuming their knowledge and societies superior to non-scientific cultures.

Anthropology developed as a discipline in Europe, and represents Europe's efforts to understand other cultures; as such, its central focus has been to search for difference and to seek out those who are most different from Europeans (Joseph et al., 1990). As a study, anthropology centres the authoritative Eurocentric voice, without

declaring its own position or location, which creates the illusion that culture is something that others have (Joseph et al., 1990; St. Denis, 2011). Anthropology developed alongside colonialism, and anthropological theories of the 19th century were used to justify aggressive colonial expansion (Battiste & Henderson, 2011; Joseph et al., 1990). In North America, anthropology began with the study of Indigenous peoples (Guilleman, 1994), and using its Eurocentric lens, anthropology ignored the unique and within group differences of Indigenous peoples, as well as their dynamic adaptations to the natural world and European contact; as a result, early anthropologists developed homogenous and static misrepresentations of Indigenous societies (Battiste & Henderson, 2011; St. Denis, 2011). As Europe also viewed itself as the single progressive society, anthropology's construction of timeless and static Indigenous cultures reinforced the notion that Indigenous people and cultures would be inevitably lost due to progress and assimilation (Battiste & Henderson, 2011).

On encountering Indigenous societies in the North American continent, Europeans understood the lack of permanent settlements as representative of emptiness, lawlessness and intellectual inferiority (Battiste & Henderson, 2011), and characterized Indigenous people unfavorably as itinerant and non-agricultural (Wolfe, 2006). These Eurocentric binaries of central/peripheral, superior/inferior, progressive/stagnant are the root of what is now an entrenched way of thinking about social difference and culture in Western societies, including Canada (Jeffery & Nelson, 2009). The binaries themselves are also deeply racist, at once centering European society as dominant and superior, and constructing Indigenous people as inferior and their societies as stagnant (Battiste & Henderson, 2011; Cannon & Sunseri, 2011). When viewed through this Eurocentric

lens, Indigenous societies would inevitably disappear, and the land could be regarded as unoccupied and 'free for the taking' (Cannon & Sunseri, 2011; Furniss, 1999; St. Denis, 2011), thus Indigenous peoples' connection to the land and their violent removal from it could also be ignored (Cannon & Sunseri, 2011). After the early genocide at the frontier, the ongoing colonial project to eliminate Indigenous peoples has been carried out through multiple pathways (Wolfe, 2006): In Canada, this has included government policies of assimilation and oppression, such as operation of the Indian Residential Schools, the Reserve system, and the Indian Act (Cannon & Sunseri, 2011).

Non-Aboriginal people in Canada now comfortably occupy positions of social privilege, and expressions of racism regarding Aboriginal peoples are at once pervasive and unrecognized. With this privilege comes the advantage of not having any experience with racism, and as a result, racism can be denied by people with white skin, and claimed to be the oversensitive imaginings of people of colour (Beagan, 2000; McGibbon & Etowa, 2009). As a result, a key property of racism in contemporary society is denial (van Dijk, 1992; Johnston & Kanistaki, 2010; Schick & St. Denis, 2003). In his program of research that analyzed the text and talk of white dominant groups in Europe, van Dijk (1992) not only documented a variety of denial strategies, but also observed that the use of racist discourse often signaled white in-group membership. For example, in settings where overt racism toward Aboriginal peoples is commonplace, white people often assume that other white people share their racist views (Furniss, 1999).

The development of a powerful constellation of discourses has been contingent with colonialism in Canada. These discourses deny social privilege as well as racism, and are used in a variety of social contexts to condone ongoing unequal relationships

between settler society and Aboriginal peoples (Schick & St. Denis, 2003). The discourse of multiculturalism, for example, is spread as a national narrative, and Canadians widely perceive themselves as tolerant and polite (Jeffery & Nelson, 2009; Schick & St. Denis, 2005). The discourse of meritocracy is also widely circulated in Canada; this discourse insists that success is the result of hard work (Cannon & Sunseri, 2011; Schick & St. Denis, 2005). These discourses are constantly at work making white privilege invisible, which, in turn, allows further denial of privilege and supports victim blaming.

Canada also has a humanitarian image that it promotes nationally and internationally. As Schick and St. Denis (2003) have argued, this is based on the assumption that an individual or a nation can secure innocence and superiority through good acts and good intentions (Schick & St. Denis, 2003). However, it is not widely acknowledged that to be able to assist others, to be generous and caring, requires a position of privilege that is dependent on the marginalization of others (Schick & St. Denis, 2003). It is also not widely acknowledged that the construction of this humanitarian image is based on the colonial justification that it is the obligation of superior races to control and ‘take care’ of the inferior races (Kelm, 1998, p. 102; Schick & St. Denis, 2003). This humanitarian image, and the discourse linking goodness and innocence of racism that accompanies it, further allows Canada to deny the violence of its colonial past (Cannon & Sunseri, 2011; Schick & St. Denis, 2003). This denial and ignorance of colonialism contributes to the phenomenon that Aboriginal people are expected to be grateful for what Canada does for them (Schick & St. Denis, 2003), and

the accompanying mainstream perception that Aboriginal people receive “special treatment.”

In the 19th century, colonial authorities in Canada (including government officials, medical practitioners and missionaries) trivialized Aboriginal healing and healing knowledge as faulty and hocus-pocus while co-opting their medicines; furthermore, these same authorities regarded the susceptibility of Aboriginal people to infectious European diseases as proof of their inferiority (Kelm, 1998, pp. 100-101). After the decimation of Aboriginal populations through frontier genocide and exposure to European diseases, colonial authorities developed and circulated a flawed but powerful argument that justified colonization, alleging that Aboriginal people were inferior, sickly and needed western medicine and civilizing to save them (Kelm, 1998, p. 101)! It is important to recognize that many present day health care providers continue to regard Aboriginal healing knowledge as inferior to Western medicine and that enduring colonial images of Aboriginal peoples continue to influence providers’ interactions: for example, the ongoing perception of Aboriginal communities as sick and dysfunctional is used to justify paternalistic treatment in contemporary health care environments (Browne & Fiske, 2001; Tang & Browne, 2008).

The discourses of multiculturalism, humanitarianism and meritocracy pervade Canadian society and public opinion, and Browne (2005) has demonstrated that these dominant discourses influence nurses’ perception of Aboriginal patients, even though they are in direct conflict with nursing ethics and standards of practice. Browne develops her thesis by showing how popular discourses, extracted from media and dominant histories, are reflected in the statements of the nurses in her study, and are visible in their

differential treatment of Aboriginal patients. Travers (1995) has argued that the discourse of individualism is also visible in professional discourses of helping in health care, and diverts the attention of health care providers away from the social and environmental causes of poor health, in favour of individual responsibility for health. This is especially true of the lifestyle approach to health promotion, which focuses solely on the risk factors for disease that are viewed to be in an individual's control. As Travers (1995) has argued, the discourse of individualism is ideological, in that it is widely circulated and rarely questioned. As a nurse educator, I have found that individualist assumptions are persistent and difficult to disrupt—they are embedded in nursing practice, reproduced in health care discourse, and continually reinforced in public messaging.

Drawing on feminist and postmodern critiques of science and medicine, Beagan (2000) theorized that individualism is contingent with an egalitarian discourse that claims that viewing people as individuals, and not as members of groups, promotes equality and transcendence of difference. Common expressions of egalitarian discourse in health care include, “we are all the same,” and “I treat everyone the same.” Tang and Browne (2008) argue that this egalitarian discourse blinds health care professionals to their differential treatment of racialized patients.

These discourses influence the attitudes of health care professionals and their interactions with Aboriginal people in profound ways. It has been well documented that Aboriginal peoples are more likely to experience an increased burden of poverty and poor health than whites, including mental illness, addiction and chronic disease such as diabetes (Tang & Browne, 2008) and recent research has shown that health care providers

often attach negative and discriminatory labels to all of these issues (Browne et al., 2011). Furthermore, this labeling behavior is especially likely when the provider does not problematize the idea that these problems are the result of individual failings.

The death of Brian Sinclair after waiting for 34 hours in an emergency room, is a potent and contemporary exemplar of how racism can and does influence the practice of providers in contemporary health care environments in Canada (Allan & Smylie, 2015; Shah & Reeves, 2015). Brian Sinclair was a homeless, Aboriginal man and double amputee who went to the hospital for a blocked catheter in 2008. Surveillance cameras showed that other patients and visitors begged nurses at the desk to help Brian; furthermore, when Brian's family asked for an inquiry regarding the involvement of racism in his death, the administration at the Winnipeg hospital similarly refused to accept that racism played a role (Allan & Smylie, 2015).

Cultural Safety and Higher Education

Since cultural safety education is focused on attitude and behavior change, many authors in Aotearoa New Zealand have shared that teaching and learning cultural safety can be challenging and uncomfortable for both students and educators (Gibbs, 2005; Richardson & Carryer, 2005; Seccombe & Roeters, 2010; Wepa, 2003; Wood & Schwass, 1993); these authors have described how the classroom can become a site of resistance and struggle between dominant and subordinated discourses, as students are exposed to histories of oppression, racist discourses and confront deeply held beliefs regarding Aboriginal peoples. As a result, it is recommended that educators develop strong facilitation skills in order to effectively manage classroom discussion and discomfort, and that educators can benefit from ongoing support and the sharing of

classroom strategies (O'Connor, 2012; Richardson & Carryer, 2005; Wepa, 2003). Given that students and educators in Western societies are all produced by a colonial system in which there is the constant recirculation of racist discourses and masking them at the same time, it is no wonder that “doing” cultural safety education in classrooms is challenging.

Another issue that arises in cultural safety education is the ambiguity regarding what makes the reflection in cultural safety *critical* self-reflection. As Spence (2005), a hospital-based nurse educator in Aotearoa New Zealand, has pointed out, practices such as journaling that are common in nursing are often focused on the self, and not on critique and social realities; as a result, such reflective exercises are limited in their capacity to stimulate change. Furthermore, several Canadian authors have pointed out that while students and educators come from diverse backgrounds, in the context of higher education, all are privileged; as a result, these authors argue that if educators wish to engage privileged learners in exposing racism and practices of oppression and privilege, they will need to take a specific approach (Cannon, 2012; Curry-Stevens, 2007; Schick & St. Denis, 2003). These same authors urge educators to talk explicitly about racism with their students in higher education, and use activities that engage students with the material, going beyond the simple provision of information (Cannon, 2012; Curry-Stevens, 2007; Schick & St. Denis, 2003).

Experiential learning. The fields of experiential learning and critical pedagogy in higher education can provide important insights and strategies for nursing educators working with cultural safety, but for the most part, the explicit links between cultural safety and these fields in higher education remain underdeveloped in the literature.

Experiential learning, for example, recognizes the important roles that experience, action and reflection have in learning (Chambers, 2009). Kolb's (1984) model of experiential learning is a continuous cycle of reflection and action that continues to be widely used and adapted to guide reflective discussion in higher education (Bender & Walker, 2013; Eyler, 2002). In this cycle, students move from having a concrete experience, to reflecting on that experience, to learning from that experience and then to actively experimenting or trying out this new learning in practice (Kolb, 1984). Not only does the experiential learning literature offer educators a toolbox of strategies for stimulating reflection, the model also connects well with nursing education, especially in clinical courses that combine classroom and clinical practice; in class, for example, educators integrating cultural safety with experiential learning can guide nursing students in reflection on their work with Aboriginal patients or issues of institutional racism that arise in clinical practice. Recent developments in experiential learning include the creation of a learning space that supports and enriches experiential learning; such a space is student-centred and provides meaningful opportunities for conversation (talking and listening) and reflective activities (Kolb & Kolb, 2005). For educators, this highlights the importance of including time for relating and connecting in class.

Experiential learning is an important dimension of teaching and learning in Indigenous traditions and is therefore especially relevant to a discussion of cultural safety. Examples of experiential learning common to many Aboriginal cultures include storytelling, sharing circles and art-based activities (Chansonneuve, 2007, p. 37-38; Hunter, Logan, Goulet & Barton, 2006), and integrating such culturally relevant teaching and learning strategies can be a part of a broader approach to create a culturally safe

learning environment for Aboriginal nursing students (ANAC, 2009a). Stories and storytelling continue to have a significant role in Aboriginal communities (Erasmus, 1989), and Indigenous authors have emphasized the importance of stories in social justice education (Brayboy, 2006; Waterman, 2013).

Spence (2005) discovered in her research with nurses in Aotearoa New Zealand that reflective storytelling is an effective strategy for stimulating critical self-reflection; as she describes, nurses using this approach share their stories of frustrations and challenges from their nursing practice in a safe and respectful environment—and this is an example of experiential learning. In the Canadian context, researchers have documented that bringing Aboriginal instructors into postsecondary classrooms is an effective strategy for teaching both nursing and teacher candidate students about colonialism in Canada (Nardozi, 2016; Shah & Reeves, 2015). In her thesis, Nardozi (2016) describes her research in which teacher candidates in Toronto participated in an Aboriginal Infusion Initiative, and Shah and Reeves (2015) describe a Cultural Safety Initiative for postsecondary students in health professions programs in Ontario. In both of these initiatives, it was discovered that an important dimension for the students' learning was the personal stories shared by the Aboriginal instructors (Nardozi, 2016; Shah & Reeves, 2015). By listening to these stories, asking questions of the instructors, and then reflecting on the experience in a post-session survey, students enter into the experiential learning cycle; as they complete the survey, students are asked to reflect on how the experience will influence their future practice (Shah & Reeves, 2015), which moves them towards the action phase of the cycle.

Critical pedagogy. Critical pedagogy is part of a constructivist conception of education, where learners are recognized as active creators of their own knowledge; this conception of education is contrasted with traditional forms of education, in which teachers regard learners as empty, passive recipients of objective knowledge (Dewey, 1938; Freire, 1970). Critical pedagogy employs small group work, in-class writing exercises and small group discussion to get students interacting, talking and collaborating in class (Shor, 1992). These strategies have been found to promote student learning and critical thinking; they also help students to develop the skills and capacity to think and talk about difficult social problems (Menashy, 2007; Portelli & Vibert, 2001; Shor, 1992). Critical thinking, for example, involves being able to view problems from multiple perspectives and recognize assumptions, (Eyler & Giles, 1999) and is developed in discussion and collaboration with others (Goldberg & Coufal, 2009). For these reasons, critical pedagogy is considered to be an important approach in teaching and motivating students for social justice and social change (Menashy, 2007; Portelli & Vibert, 2001; Shor, 1992), and therefore connects well with the goals of cultural safety.

Anti-racist pedagogy and anti-oppressive pedagogy are two examples of critical pedagogies that have special relevance for nurse teachers attempting to integrate cultural safety education into their courses. Both challenge traditional approaches to education, are focused on social change, and offer educators a wide-range of strategies for focusing on racist power relations, exposing systems of oppression and analyzing the social construction of race (Cochrane-Smith, 2000; Curry-Stevens, 2007; Jeffery, 2007, 2009; Jeffery & Nelson, 2009; Schick & St. Denis, 2003; St. Denis, 2011; Varcoe & McCormick, 2007). Cannon (2012), for example, recommends that educators begin by

building common ground with privileged learners, and then address privilege, social inequity and injustice as a community of learners in the classroom context. Cannon suggests that discussions about capitalism, consumerism and environmental degradation are effective ways to build common ground in the classroom with privileged learners. With common ground, educators can lead the class into an exploration of settler colonialism and the oppression and exploitation of Indigenous people (Cannon, 2012). For example, moving this way into a discussion of the colonial history of Canada helps learners to understand that the benefits of colonialism will give no-one shelter from environmental destruction (Cannon, 2012).

As another example, Schick and St. Denis (2003) provide a description of their cross-cultural education course that they use with teacher candidates, showing how they develop a critical social analysis in the classroom. These educators begin their course by examining the connections among power, knowledge and social difference, and then focus on unpacking ideological assumptions. Schick and St. Denis prepare a set of guiding questions for each reading, and then take the class through an ordered examination of topics: first, the class examines the production of identity and difference; next, they explore the construction of race privilege in Canada. The authors emphasize the importance of including readings of the histories of racially marginalized groups in their course (Schick & St. Denis, 2003). Knowledge of these alternative histories challenge the assumption of Canada as a fair country, by showing how the silencing of these other histories has been central to nation building in Canada (Schick & St. Denis, 2003).

Becoming an ally. Shah and Reeves (2015) argue that cultural safety education is meant to help health science students develop empathy for the Aboriginal people they work with, which can then inspire students to act in solidarity with Aboriginal peoples. Combined with the skills developed in experiential learning and critical pedagogy, including respectful listening, critical thinking, critical reflection, and being able to talk about difficult issues, students can learn to become allies with Aboriginal peoples. An ally is defined as “a member of an oppressor group who works to end a form of oppression which gives them privilege” (Bishop, 2003, p. 152). There is a small amount of literature that talks explicitly about the process of becoming an ally, which has important connections with the foregoing discussion of cultural safety in nursing and higher education; for example, being an ally requires being able to listen (Bishop, 2003; Max, 2002; Regan, 2010; St. Denis, 2010). Other dimensions of the ally role include taking the lead in speaking up against racist and oppressive comments, building relationships with Aboriginal communities, and engaging in a continuous and life-long process of critical self-reflection (Bishop, 2003; Max, 2002), dimensions that also connect well with cultural safety. St. Denis (2010) argues that an important characteristic of a good ally includes being able to participate in the community without trying to be the centre of attention, the authority or the rescuer. Regan (2010) adds that to become an ally, non-Aboriginal people must be willing to get uncomfortable, as discomfort is part of the process of acknowledging that privilege in Canada has required the oppression of Aboriginal peoples.

Cultural Safety and New Nurses

As stated above, many authors in the Canadian context have argued that cultural safety is about healing relationships, and that culturally safe interactions between nurses and their Aboriginal patients and clients must be marked by respectful communication and collaborative approaches (ANAC, 2009b). However, building relationships with patients takes time, and the cultural safety literature for the most part does not acknowledge that nurses' time, especially in contemporary hospital environments, is often considerably constrained. For insight on this dimension of nursing practice and its implications for early career nurses, the school-to-work transition literature in nursing provides some insights.

Most nurses begin their careers in the hospital (Hodges, Keeley & Troyan, 2008) and managing heavy workloads and not having enough time to spend with patients is often identified as a key source of stress for nurses transitioning from student to practicing professional (Hodges et al., 2008; Honan Pellico, Brewer & Tassone Kovner, 2009; McCalla-Graham & De Gagne, 2014; Peterson, 2009). As many authors point out, cost containment and efficiency issues have become a persistent feature of modern health care, and new nurses (as well as their senior colleagues and managers), often judge their progress and performance as novice professionals by their ability to handle their workload (Boychuk Duchscher & Myrick, 2008; Limoges, 2007; Peterson, 2009). Although job stress for nurses transitioning from student to practicing professional has been reported in this body of literature since the 1970s (Peterson, 2009), added administrative duties and increasing patient acuity have continued to add to the intensity of work and job stress for nurses in acute care in recent years (Honan Pellico et al., 2009;

Morrison & Korol, 2014). However, as Price and colleagues (2013) note, recent studies have indicated that traditional ideas regarding helping others and making a difference continue to inform the choice of a career in nursing (Hodges et al., 2008; Price, McGillis Hall, Angus & Peter, 2013). This dissonance between the realities of hospital nursing and ideals about nursing as a career understandably interferes with job satisfaction (Honan Pellico et al., 2009; McCalla-Graham & De Gagne, 2014; Peterson, 2009; Price et al., 2013). This dissonance also contributes to high rates of attrition of new nurses, which is often the primary concern in this body of literature. Of concern for me in this study was the gap in the literature regarding how early career nurses navigate the tension between the time required for building relationships in order to provide culturally safe care, given the time constraints of their hospital jobs. Knowing the realities of hospital work and the job stress experienced by new nurses, as a nurse educator and researcher, I also wanted to explore the relevance of cultural safety education for nurses early in their careers.

Another issue I planned to explore that is not addressed in the literature was in relation to the learning that happens when early career nurses enter into respectful, collaborative relationships with their Aboriginal patients at work. As stated above, the cultural safety literature emphasizes that cultural safety education helps health science students to develop empathy. As a nurse educator, I have witnessed an awakening to the harms of colonialism and the development of empathy in my nursing students in the nursing courses that I teach in Aboriginal health. Cultural safety however, is meant to be knowledge that is carried into practice, and going into my study I wanted to understand what translating this knowledge into practice looked like for early career nurses. Michael DeGagne, the Executive Director of the Aboriginal Healing Foundation, emphasizes that

listening to clients' stories is an important aspect of establishing culturally safety with people whose identities have been forcibly repressed in residential school (DeGagne, 2007), and I have encouraged my students to do so with their Aboriginal clients and patients since becoming a nurse educator in 2009. Over the years, many of my students have shared moments of deep and transformative learning from their nurse-patient-relationships with Aboriginal patients, and one of the main goals of my study was to collect data on the learning experience of early career nurses in this regard.

As discussed in the previous section, learning how to talk about difficult social issues is an important dimension of critical pedagogy. When I first began my work as an educator, students told me how they struggled with the racist and discriminatory comments of their nurse colleagues. As students shared with me, they were often unable to speak up due to their vulnerable position as students, and their silence made them feel complicit in the overt racism expressed by fellow nurses. There is a very limited amount of literature that addresses the topic of speaking up in nursing, especially as it relates to new nurses, and what is available in the literature is in reference to patient safety. These papers discuss some of the challenges nurses face when they try to raise concerns regarding patient safety with colleagues and superiors, and indicate that nurses often avoid conflict and don't speak up, especially when hierarchies and power differences are involved (Attree, 2007; Sayre, McNeese-Smith, Searle & Phillips, 2012). Law and Chan (2015) have documented that learning to speak up is a process for new nurses that requires mentorship and a safe environment. Of interest, Sayre and colleagues (2012) documented the success of an educational intervention with practicing nurses that involved interactive group discussion, practice-based scenarios, reflection, visioning for

future action and collegial support—dimensions of experiential learning and a critical pedagogical approach. Scholars in anti-racism and anti-oppression education provide strategies for educators for facilitating difficult conversations about race and privilege, and note that such conversations require planning, practice, and civic courage (Carpenter & Diem, 2013; Miller, Donner & Fraser, 2004). This literature, however, does not directly address how nurses tackle speaking up about racism in contemporary health care settings, and in this research study I wanted to learn more about new nurses' experiences addressing racism in their work environments.

In my study, I also planned to explore the context of nurses' experiences with racism expressed toward patients, and if and how early career nurses intervene, given the challenges and hierarchies for new nurses in contemporary health care environments. Students have often shared that they hear discriminatory comments about patients with chronic illnesses, especially in emergency departments. Research has shown that over the past two decades, the number of family physicians has decreased and a widening gap in primary care services has developed in Canada (Health Council of Canada, 2008). As a result, options for primary care services are insufficient to meet current needs, and emergency departments are often the only option for many communities, including Aboriginal communities, to access primary care services (Clarke, Usick, Sanderson, Giles-Smith & Baker, 2014). Rural communities often have particularly limited options for primary care services, and choices for remote communities are even more constrained (Rural and Northern Health Care Panel, 2011). As a result, many of the patients in Canadian emergency departments have health needs that are not triaged as needing emergency medical attention (Canadian Institute for Health Information, 2014). For these

patients, their use of the emergency department is considered “inappropriate,” and health care providers often label such patients who access emergency services regularly as “frequent users” or worse, as “frequent flyers” (Bernstein, 2006). Patients labeled in this way are in need of respect and care since they are living with ongoing physical and mental health issues including, for example, alcoholism and addiction; they are very familiar with stigma and are aware when they are being labeled in this way (Bernstein, 2006; Clarke et al, 2014). Although being labeled are not experiences that are exclusive to Aboriginal peoples, being made to feel that they are undeserving patients based on their identity is (Browne, et al., 2011). Browne and colleagues (2011) however, have demonstrated that these same patients remember the moments when they are treated with respect and dignity. This has critical implications for cultural safety and the practice of new nurses, given that new nurses have likely chosen the profession of nursing to make a difference and are often working in incredibly demanding and hectic hospital settings.

Conclusion

In this chapter I have discussed how the concept of cultural safety must be connected with a discussion colonial rhetoric and racism, and have focused on how Eurocentric discourses regarding Aboriginal peoples influence nursing practice. Given that cultural safety is meant to be integrated into nursing education, I have also shown how experiential learning and critical pedagogies, including anti-racist pedagogy and anti-oppressive pedagogy, offer nurse educators important strategies for this challenging work. The practice environment is, of course, central to my study as well, and I have also explored the school to work transition literature to illuminate important dimensions of the

professional practice experience for early career nurses. This chapter, along with the discussion of my research methods in the next chapter, will serve as the lens for the data chapters that follow.

CHAPTER 3

THEORETICAL PERSPECTIVE AND RESEARCH METHODS

Introduction

In this chapter I will begin with a discussion of the postcolonial foundation of my study, the evolution of my standpoint as a researcher and how this influenced the direction of my study and my choice of participants. I then review my rationale for choosing Situational Analysis (SA), a postmodern adaptation of Grounded Theory Methods (GTM), and how it proved to be an appropriate method and methodology for my study. My discussion illustrates how theoretical sampling, an important dimension of GTM, influenced the development of my research and the expansion of my study to include interviews with experienced northern nurses. In this chapter I also describe how I used constant comparison, SA and mapping in my analysis and in the writing of my data chapters.

Theoretical Perspective: Postcolonial Theory

In chapter two, I opened my discussion of racism and racist discourses in use in Canada by aligning my argument with that of other authors who locate racism at the centre of colonialism in Canada. Because postcolonial theory gives explicit attention to colonialism and recognizes it as a contemporary and corrosive force in society (McGibbon & Etowa, 2009), it is especially suitable as the theoretical framework for my study. Postcolonial theory examines the assumptions of colonialism and links colonial oppression and racism with present-day (neocolonial) discriminatory practices in society and social institutions, including health care (McGibbon & Etowa, 2009). Contemporary

health care in Canada is provided in a neocolonial context, and postcolonial perspectives can therefore provide an important framework for nursing research and practice in order to facilitate an understanding of how colonial relations are reinscribed in the present (Browne, Smye & Varcoe 2005). As discussed in chapter two, Anderson and colleagues (2003) have stated that the purpose of a postcolonial lens is to expose Eurocentric and colonizing practices that have centred European people and values, and subordinated non-European people as the “Other” and inferior. For Aboriginal peoples, the universalizing discourses of Eurocentrism have been used to separate Aboriginal peoples from their children, languages, land, histories and Elders (Battiste, 2005). Postcolonial theory is also acknowledged as the theoretical framework that underpins cultural safety (ANAC, 2009b; Browne, Smye & Varcoe, 2005). Linking postcolonial theory with critical self-reflection, the concept of cultural safety guides health care providers to think critically about themselves, and to be attentive to local histories, especially colonial histories, that influence their location and that of their patients (Anderson et al., 2003).

Initially the term postcolonial was used to refer to the historical period when countries (former colonies) regained their political independence from Europe (Nayer, 2016). However, given that postcolonial theory examines the assumptions and present-day legacy of colonialism, it is clear that the term postcolonial is not used to signify that colonialism is over. Rather, as Marie Battiste (2011) argues, Eurocentrism and colonialism continue to dominate the global landscape at individual, social, systemic and epistemological levels, and as such, postcolonial theory is about challenging and rejecting Eurocentrism and colonialism. Anti-colonialism is also about exposing contemporary colonial practices, but extends to self-determination (Sunseri, 2011) and seeks to correct

the misrepresentation of Indigenous peoples by centering Indigenous knowledges (Shahjahan, 2011).

Position and Method

When I first began to think about a research project and becoming a researcher, a memory from my nursing career surfaced: I was standing with one of my Aboriginal nurse colleagues in a First Nations community health centre, and she said plainly, “Aboriginal people are so sick and tired of being researched.” Her comment came in response to the large box of lengthy Canada Census forms that we were trying to make room for among the health education leaflets and community announcements in the health centre’s entryway; as time passed the census forms were still there, untouched and gathering dust. Five years later, as a master’s student, I read Linda Tuhiwai Smith’s 1999 book, *Decolonizing Methodologies*; while I read the whole book, it was the opening paragraph that became a powerful and memorable moment from my graduate studies:

The word itself, 'research', is probably one of the dirtiest words in the indigenous world's vocabulary.... It is a history that still offends the deepest sense of our humanity. 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. (Smith, 1999, p. 1)

Reading this passage created an arc of connection to my memory of those dusty census forms and a deeper understanding of my colleague’s words. As I continued to move through my graduate studies I read more and more about the colonial history of anthropology and Eurocentric research in Indigenous communities, and the vast amount of research that had been done on the people that had not benefitted them or their communities. More than one text emphasized, just as Smith had in her 1999 text, that

western academics had a reputation of going into communities and taking their knowledge and doctorate degrees with them when they left.

At the same time I found myself questioning my own interest in Aboriginal health, and wondering what my contribution to the field could be, without contributing to the colonial history of research abuses in Aboriginal communities. In short, I wondered if and how I, as a Euro-Canadian settler and academic, could be an ally to the community as an educator and researcher in higher education. As I progressed through my graduate studies as a doctoral student, I found confidence in aligning my position with other scholars in higher education who explain that it is important that all educators participate with their students to unlearn racism (Cochrane-Smith, 2000; Hassouneh, 2006), and in the Canadian context, that it is the responsibility of all non-Aboriginal people to learn about the history of colonialism and reflect on our relationship with this history in the present (Cannon, 2012; St. Denis, 2011). With the support and guidance of the local First Nations community at my university, I began to find my way as an educator, through the development of courses in urban and rural Aboriginal health and my involvement in a local cultural safety initiative; I began to foreground the model of cultural safety in my teaching, and explored, alongside my nursing students, the history of colonialism in Canada and the continuing impact of racism and colonialism on the health of Aboriginal communities. Still, as a researcher, I puzzled over the questions I wanted to explore and the method appropriate for my doctoral research study.

I explored several methods, including phenomenology, narrative and feminist research methods, as well as case study research. Given my area of interest, I also explored Indigenous research methods, and reviewed *Indigenous Methodologies* written

by Margaret Kovach (2009). I read more of Smith's writings, including her chapter, *On Tricky Ground*, in the third edition of Denzin and Lincoln's *Handbook of Qualitative Research* (2005). Close readings of these two texts brought me to a deeper appreciation of Indigenous Knowledges and the principles for ethics in First Nations research (Ownership, Control, Access and Possession) developed by the First Nations Information Governance Centre², as well as Indigenous protocols in writing regarding introductions and declaring position and the sharing and dissemination of knowledge to communities. These texts reinforced my standpoint critiquing the colonial history of Eurocentric research in Aboriginal communities and my responsibility as a non-Aboriginal researcher in the field of Aboriginal health. As a doctoral student, I had found my position: I felt that that I could ethically contribute to the post-colonial project, by focusing on nurses and racism in health care, with the theoretical framing created by Aboriginal peoples speaking through the concept of cultural safety. With my position nailed down, I still needed a method.

It was in a research methods course that my supervisor noticed my practice of taking notes in class—I often draw diagrams with circles and arrows to reveal the relationships among the concepts under discussion; I have a distinct memory of being in that class, writing and drawing in pencil as I listened and created a graphic representation of my understanding. After class my supervisor brought my attention to my note-taking practice and its visual similarities with Adele Clarke's maps, and soon I was reading Clarke's 2005 book, *Situational Analysis: Grounded Theory after the Postmodern Turn*. As I have already discussed, I was well acquainted with the concept of cultural safety and

² OCAP® is a registered trademark of the First Nations Information Governance Centre (FNIGC). Please go to www.FNIGC.ca/OCAP for more information.

its postcolonial underpinnings. Going into my project I knew that I wanted to explore racism in health care toward Aboriginal people and how it is circulated and continually reproduced in nurses' talk. Given the complexity of contemporary health care environments, and the dominant discourses and social structures that reinforce colonial attitudes, it was important to choose a method that could handle interview data as well as analyze discourse. Discovering that this was a strength and important dimension of Clarke's Situational Analysis meant that I had found a method that could do what I needed it to do, a method that could guide me through the analysis of these complexities, and a method that resonated with the way I process and understand information on a conceptual level. Finding a method, exploring it and settling on it opened the door of my research interest onto my research project, and allowed me to move forward. Whereas my earlier explorations of methods reinforced their limitations or incompatibility with what I wanted to do, Clarke's Situational Analysis approach made it possible for me to start writing my research proposal and ethics protocol, and thereby begin focusing on the details of my study.

Methodology: Grounded Theory

Clarke was a student of Anselm Strauss, one of the founders of Grounded Theory Method (GTM). While early GTM had positivistic leanings, Clarke (2009) developed her method as a way to think about, study and analyze discourse as part of social worlds, making it an especially relevant method for the study of nursing practice. Since my study is of interest to the nursing research community, choosing a method that is familiar to nursing scholars will also assist in communication of findings. Grounded theory is used

when the researcher wants to learn from participants about their perspectives on a situation. Situational analysis allows researchers to pursue in-depth investigations in context, and although SA diverges from GTM in significant ways, as a method it uses key components of GTM, including theoretical sampling and constant comparison (Clarke, 2009). Constant comparison involves comparing interview transcripts and tacking back and forth between data collection and analysis to tease out theoretical insights. The purpose of GTM is to try to “open-up” the data to discover meanings. The object of study in grounded theory is meaning that arises in human interaction.

As a student of Anselm Strauss, Clarke (2009) argues that using GTM in a postmodern way requires explicit attention to discourses in analysis, and SA integrates the study of meaning in human interaction together with discourses and sociocultural or symbolic conditions. The context of study in SA is “the situation” or “social world” which includes the context, the people in it, their relationships, actions and interactions with each other. Examples of a social world can include a hospital, community health centre, or the nursing profession, illustrating the relevance of an SA perspective for my study. Bringing GTM “around the postmodern turn,” involves naming what Clarke identifies as implicated actors and implicated actants (non-human actors), where *implicated* refers to actors and actants that are silent, silenced or not physically present but still influential (p. 204). An example of an implicated actant in my study is the discourse of racism: although health care providers may not talk about racism or may deny the existence of racism in the provision of health care services, it is nonetheless influential in health care interactions.

Strauss developed the “conditional matrix” in which diagrams with concentric circles were used to make structural conditions visible in analysis (Clarke, 2009, pp. 207 – 208). Influenced by Strauss, Clarke has made use of maps and mapping as a key technique in situational analysis. However, Clarke has critiqued Strauss’s use of concentric circles as a flawed view of social life, because the conditions are *in* the situation and not around it. For Clarke, the diagram or map as a whole is the situation of inquiry, containing the conditions that constitute and affect most or all of everything in the situation. A situational map may be “ordered” or “messy” and explicitly specifies all of the important conditions in the situation being studied, making SA mapping an especially useful tool in the research planning stage (Clarke, 2009, p. 210 – 218).

Clarke (2009) recommends that researchers make a map during the research planning stage of their project, and as a part of my research proposal I created both a “messy” and an “ordered” situational map; on the messy map I brainstormed all of the anticipated actors, actants and discourses that I thought would be relevant to my study before I began data collection; I then used this messy map to create the ordered situational map presented in Figure 1A (p. 50). I used some of Clarke’s maps as starting points for the construction of my own maps and have included an example of an ordered situational map created by Clarke in appendix E1. Clarke suggests that researchers use the following categories to help them identify everything that may be of importance in their study: individual and collective human actors, discourses, implicated or silent actors and actants (who and what is not physically present but still important), sociocultural or symbolic elements (such as religion, race, culture, nationality, icons, etc.), spatial or geographical elements, and major issues or debates (Clarke, 2009, pp. 213).

Figure 1A: Ordered Situational Map for Research Planning

<p>Individual Human Actors Early career nurses Nurse managers Nurse educators Non-nurse health staff</p> <p>Implicated Actors Aboriginal peoples</p> <p>Nonhuman Actants Agency policy documents, mission statements Charting systems ANAC Cultural Safety document Nursing education texts and documents</p> <p>Sociocultural / Symbolic Conditions Stereotypes about Aboriginal peoples Aboriginal Inclusion Organizational cultures Nursing unit/ward cultures Power relations</p>	<p>Collective Human Actors nursing groups (ANAC, RNAO)</p> <p>Discourses Caring Professionalism Culturalism Racism Meritocracy Biomedicine Egalitarian discourse Helping Individualism</p> <p>Related Discourses Neoliberalism Standardization Efficiency Managerialism</p>
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Figure 1B: Ordered Situational Map Based on Interviews 1 & 2

<p>Dimensions of cultural safety Cultural safety takes time Building relationships with Aboriginal clients and staff helps nurses understand peoples' lived experience Cultural safety is linked with relationships in practice Cultural safety is felt in meaningful connections with patients Heavy workload interferes with relationship building Biomedicine and technical skills are valued over cultural safety, relationship skills and compassion Hands-on leadership needed</p> <p>Discourses: Colonialism Racism Paternalism Efficiency Biomedicine</p> <p>Sociocultural & Symbolic Conditions Many people are unaware of colonialism and its impact on Aboriginal communities Truth and Reconciliation Commission Power and powerlessness Stereotypes and labels including "frequent flyers"</p>
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As indicated in Figure 1A, the individual human actors that I identified during the research planning stage were early career nurses, nurse managers, nurse educators and non-nurse health staff, while the collective human actors that I identified included the Aboriginal Nurses Association of Canada (ANAC) and the Registered Nurses Association of Ontario (RNAO). Although I did not plan to interview Aboriginal community members or patients in my study, their presence would certainly be felt and central to my study, and I identified them in this map as implicated actors. As I discussed in my literature review, there are numerous discourses that are relevant to my study, and in this map I included the following discourses: caring, professionalism, culturalism, individualism, meritocracy, biomedicine, racism, helping and egalitarianism. Under the heading of “Related Discourses,” I identified other discourses that I considered important, including neoliberalism, standardization, efficiency and managerialism. Although I included many relevant discourses in this pre-research map, notably absent is *colonialism*, which I came to appreciate as the key organizing discourse of my study once I began data collection.

As noted in my literature review, many authors have argued that the practice and policy environment also exert influence on the ability to practice cultural safety (Brascoupé & Waters, 2009; Van Herk et al., 2012), and the nonhuman actants that I added to this first map included health policy documents, agency policies and mission statements, published scholarly literature regarding discourses that influence nursing practice, and texts or documents from the education programs of nursing graduates. Although Clarke recommends these categories as a starting point, she also insists that they are just guides that can be discarded if not relevant to the situation being examined;

pursuant to GTM methods including theoretical sampling, this would mean that it would be my participants' interviews that would determine who and what would be included in the maps I would create as I moved forward and progressed through data collection. This dimension of my data collection and Figure 1B, will be discussed in *Situational Analysis and Map Making*, below.

Recruitment, Participants and Transcription

I began my study by recruiting early career nurses who were graduates of the Bachelor of Science in Nursing (BScN) program where I teach. The rationale for this starting point was that I was familiar with this program and knew that cultural safety had been introduced into the curriculum in 2011. Inclusion criteria were that potential participants had been working as registered nurses (RNs) anywhere in Canada, and had opinions about cultural safety as well as experience working with Aboriginal patients/clients that they wanted to share. I defined the “early career nurse” as a nurse with up to five years of experience as an RN. With approval from the university's central office of research ethics and the faculty of nursing's research ethics board, I was able to proceed with recruitment and posted a recruitment notice on the school of nursing's Facebook and Twitter pages (Appendix A1). Many alumni remain connected to the school of nursing after graduation, and I hoped that using these social media platforms for recruitment would mean that my poster could reach graduates of the nursing program regardless of where they were living and working. As an educator, I knew that nursing students benefitted from debriefing about their experiences, especially difficult or challenging ones, and I expected that nurses would come forward, because they

welcomed the opportunity to talk about these topics. I estimated that my interviews would be 60-90 minutes in duration.

As I waited for participants to come forward I shopped for a digital audio recorder; I chose one with a built-in USB key that would allow me to transfer audio files directly onto my computer. As a novice researcher, it was my intention to transcribe my own interviews so that I could evaluate my interviewing technique and adapt my interactions with participants as I progressed through data collection. My first interview was 71 minutes in length; after one hour of transcribing I was unnerved to realize that I had only transcribed 3 minutes of the interview! Briefly I considered hiring a transcriptionist to do the job; however, the cost of transcription in my city (one to two dollars per minute) was a significant deterrent. I then explored a variety of voice to text software options, but learned that such software needs to be trained to recognize the voices in the interviews to be effective. I finally settled on using a transcription pedal and headphones, with a program that would allow me to stop and start the recording with the tap of a foot. By the time I had finished transcribing that first interview, I had also discovered the value of the autocorrect function on my computer; gradually I created 85 contractions of words and short phrases that I was encountering frequently in my interviews. Using the foot pedal along with autocorrect allowed me to increase my transcription speed to 10-12 minutes of interview per hour. While this speed could still be considered not fast enough by some standards, I settled into a routine of transcription; I found I truly enjoyed the process of listening intently to my interviewees, and being suspended in these conversations for the time required to transcribe them. Through this

process I discovered that doing my own transcription was a highly appropriate and relevant way to engage with my relational data and its meaning (Della Noce, 2006).

As I was figuring out how to proceed with transcription, early career nurses were responding to my recruitment poster, and I sent each respondent a copy of my recruitment letter (Appendix A2) by email. If they agreed to participate, the nurses were provided with a letter of information about the study (Appendix B1) and a copy of the consent form (Appendix C), which were also sent via email. With all of my participants I began the interviews with a review of the letter of information and an offer to answer any questions about the study before proceeding. While I was able to interview most of my participants in person and obtain a written consent, I conducted a small number of interviews via Skype and telephone; with these participants I obtained a verbal consent of which I made a written record.

Interviews in GTM cannot be overly structured or limited by the researcher's predetermined set of questions. I chose a semi-structured, open-ended interview style to remove the constraints of structured interviews, and allow participants to share their stories and perspectives. I created a set of draft interview questions for my proposal to loosely guide the interviews (Appendices D1 and D2) and began my interviews with the collection of personal information including their name, email address, the year the participant graduated from their nursing education program, their current position as a nurse and any other nursing positions they had held since graduation. I then asked the nurses about their understanding of cultural safety, the cultural safety education that they received during their nursing program and if it had been useful to them in their practice as a nurse. During the interviews, I asked the nurses to reflect on their experience and

knowledge of Aboriginal peoples, including educational opportunities at work and/or experiences prior to becoming a nurse. Interview questions also explored the participant's experience with Aboriginal patients as a registered nurse, as well as situations in which they thought that an Aboriginal person might not have felt safe; most of my participants had experienced such situations, and my next move as a researcher was to explore their perspective regarding what aspects of the situation they thought contributed to the Aboriginal person's discomfort and their own ability or inability to intervene. Given the hierarchies embedded in health care systems, it is not surprising that observations regarding hierarchies and power relations often emerged in my conversations with participants; I asked participants for their perspectives on ways to minimize power imbalances between nurses and patients, and the barriers and supports to culturally safe practice in their work environment. As the energy of each interview began to wane and I sensed that our conversation was coming to an end, I always asked my participants if they would like to share additional information and perspectives on any of the topics we had discussed; this final question often prompted the participants to share important insights before the completion of the interview. For example, when I asked one early career nurse this question, she shared how the high rates of cancer that she had observed in one Aboriginal community had been the catalyst for her to get involved in climate justice work. When I asked another early career nurse this question, she talked in more depth about how the influx of early career nurses, who had learned about cultural safety as students, were influencing a change in the conversation about Aboriginal issues at her workplace.

Of my first five interviews, three were held in person and two were conducted using Skype. One of these Skyped interviews was with an early career nurse living and working in a rural community in a northern region of Canada. This nurse encouraged some of her early career nurse colleagues to contact me so that they could participate in my study. As participants came forward, I decided to travel to this rural community as part of my data collection process so that I could conduct these interviews in person and make field notes that could ground my perspective of living and working in this area. These participants had different educational backgrounds and diverse life experiences, which also enriched my data.

In my experience as a nurse and nurse educator, I am aware of the influence that nurse managers can have on the working environment experienced by staff nurses. As a result, and as indicated above in Figure 1A (p. 50), I included nurse managers and educators in my group of individual human actors in the situational map I created before I began data collection (and in my ethics protocol as well). While my starting point was to interview early career nurses, using GTM meant that theoretical sampling could cue me to interview nurses occupying leadership roles, if nursing leadership emerged as important to my participants. In my first interview, for example, an early career nurse shared that stronger leadership and a more hands-on nurse manager would, in her opinion, support the practice of cultural safety in that hospital. After all of the early career nurses in my first five interviews had talked about nurse managers and/or senior nurse colleagues as important to their practice and mentorship in cultural safety, I knew, without a doubt, that interviews with experienced nurses would add important perspectives to my study. My data was also telling me that interviews with experienced

nurses would add insight on the context that supported culturally safe nursing practice, especially if they had been working in areas that involved the provision of service to a significant population of Aboriginal peoples. Given that numerous Aboriginal communities are served by rural hospitals in northern areas, I turned my efforts to the recruitment of seasoned nurses working in such locations.

I began by researching rural hospitals in northern communities online, exploring hospital mission statements and policy documents for references to Aboriginal inclusion, as well as information regarding programming that was designed to meet the needs of a local Aboriginal population. Once I had identified two potential locations, one with a well-developed cultural safety program and the other without, I sent emails to the sites' nursing leadership using their publicly available contact information, and included a letter of information to describe my study (Appendix B2). One of these locations responded to my inquiries, and after obtaining the required ethics approval, I was able to travel to this location for the purpose of interviewing experienced northern nurses working in this rural area. For the purposes of my study I defined the experienced nurse as a nurse with ten or more years of experience.

My interviews with these experienced northern nurses began with the collection of personal information including their names and email addresses, a description of their current positions, the length of time in the position, and then previous positions and the length of time they had worked as nurses. I also asked the experienced northern nurses to talk about their nursing education, the focus of their training and education, and their current philosophy of nursing, to document what they prioritized in nursing practice. Most of these participants were familiar with the concept of cultural safety and I asked

them, just as I had with the early career nurses, to describe their understanding of the concept or their approach to working with difference in nursing. These nurses had 11 to 30 years of nursing experience, and had all encountered a variety of workplace educational opportunities regarding working with Aboriginal people in health care; as a result, they had opinions regarding effective and not-so-effective ways to educate nursing staff and promote cultural safety. In these interviews, I probed the participants' perspectives on the challenges that health care providers experience when they work with Aboriginal patients, and if these challenges were different for new nurses. In addition, I asked them to share if they felt their current work environment was supportive of culturally safe practice, and why or why not. As the interviews drew to a close, I also offered these participants the opportunity to share additional perspectives on the topics discussed during the interview.

In my proposal I estimated that I would need to interview approximately 15 to 20 early career nurses and five other health care providers to answer the research questions of my study. In GTM, data collection lasts as long as insight continues to emerge from the ongoing analysis (Glaser & Strauss, 1967). Richards and Morse (2013) add that qualitative researchers will know they have enough data when the data is 'sounding familiar' or they have 'heard the whole story' (p. 196); I recognized that I had reached this point after interviews with 20 nurses. To summarize, 13 of my participants were early career nurses and seven were experienced northern nurses. I interviewed most (15) of my participants face-to-face, and used Skype to conduct three interviews and the telephone for two others.

During my year of data collection, I travelled to four rural communities, where I interviewed nine of my participants. As a group, the 20 participants shared their experiences of working in 12 different sites, including four rural hospitals, three rural community-based agencies (including two clinics and one home-care service), two nursing stations, one small urban hospital and two large urban hospitals. These sites are located in ten different communities in Canada, including two remote communities (without year-round road access), five rural communities, two large urban centres and one town. To protect the anonymity of the participants and the locations where they work or have worked, I randomly assigned each participant a pseudonym and have kept the site names and locations confidential (Table 1, Participants). In the table, the notation

Table 1: Participants

Pseudonym	Primary Site	ECN or ENN and Secondary Site
Anne	Rural hospital	ECN
Patty	Rural hospital	ENN, works at a rural hospital and travels to remote nursing station
Tammy	Rural hospital	ENN with leadership and management experience
Rachel	Rural hospital	ENN
Skylar	Rural hospital	ECN with Aboriginal ancestry, currently working at an urban hospital
Naomi	Rural hospital	ECN currently working at an urban hospital
Brenda	Rural community-based clinic	ECN
Fran	Rural hospital	ECN
Helen	Rural hospital	ECN
Dawn	Rural hospital	ECN
Gordon	Rural hospital	ECN
Ivy	Rural hospital	ECN
Meg	Rural hospital	ENN with leadership and management experience
Evelyn	Rural hospital	ECN currently working in small urban hospital
Kelly	Rural hospital	ENN
Jolene	Rural hospital	Aboriginal nurse, ENN. Currently works in rural homecare
Logan	Rural community-based clinic	ENN
Sam	Urban hospital	ECN in urban emergency department; Locum in remote community during first year of career
Nancy	Urban hospital	ECN in urban hospital; Locum in remote community during first year of career
Cathy	Urban hospital	ECN in urban emergency department for 3 years

for early career nurses is ECN, and the notation for experienced northern nurses is ENN; 'Primary Site' refers to the workplace where the nurse began working or currently works, and the 'Secondary Site' refers to the workplace where the nurse currently works, if applicable.

Situational Analysis and Map Making

With theoretical sampling and constant comparison built into my data collection process, it was important that I begin data analysis immediately after my first interview. As part of my process I would review the transcript, making notes in the margins and highlighting important quotes. In addition, I would also write field notes on my impression of the interview that I had just transcribed, and then create a situational map or maps, in pencil, to accompany each interview. My deep engagement with my interviews through transcription helped me to create these situational maps, which in turn allowed me to identify codes arising in my data. I created both ordered and messy situational maps for the first three interview transcripts; however, as I moved forward in my data collection, I created more messy maps than ordered maps, as I found that the making of messy maps was helping me to conceptualize and interrogate my data more effectively. I used a variety of graphics in my maps to represent different conditions, including shapes, pictures, words, and arrows, as well as solid and broken lines to represent strong and weak connections respectively. I often used overlapping circles to indicate interrelated dimensions of a concept, and distinct circles to indicate emerging codes. I also made use of arrows to show the direction of influence. As a result, the messy situational maps that I created were different from the maps published by Clarke, and

they were also different from each other: for example, when one nurse described the hospital as a bottleneck where the harms of colonialism accumulated, I drew an open-ended bottle with block letters spelling “colonialism” crowded together and piling up in the neck (Figure 2A); after two nurses described how their upbringing had nurtured their

Figure 2A: Situational Map of Interview 6

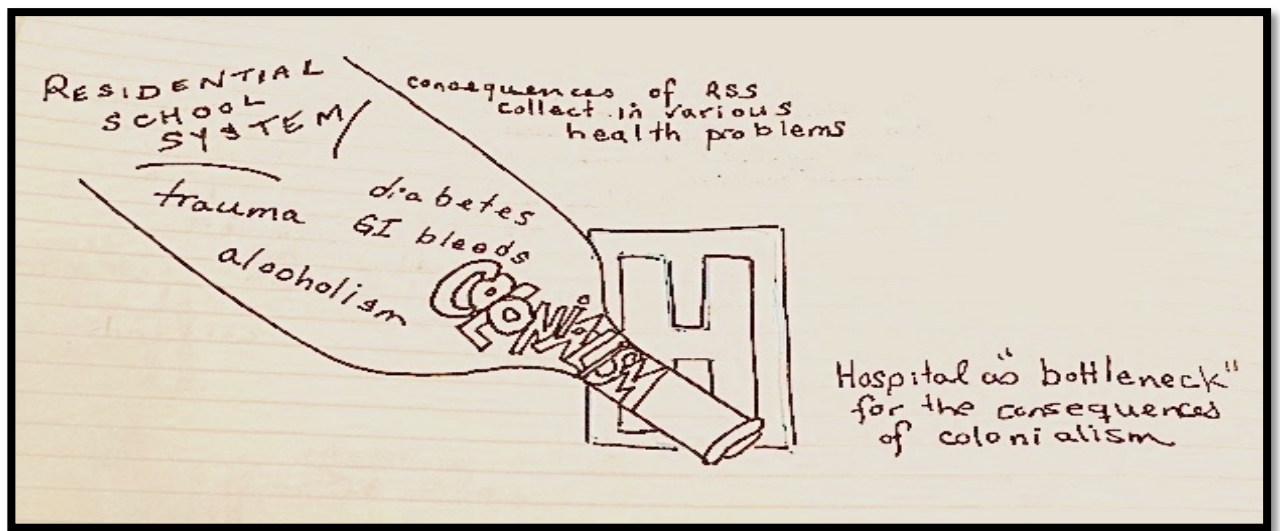
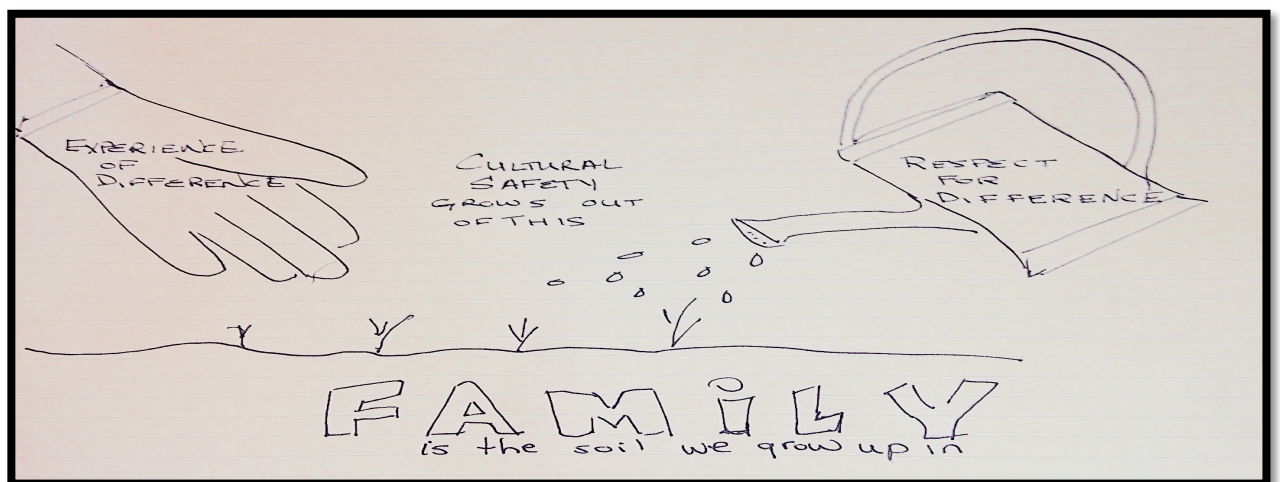
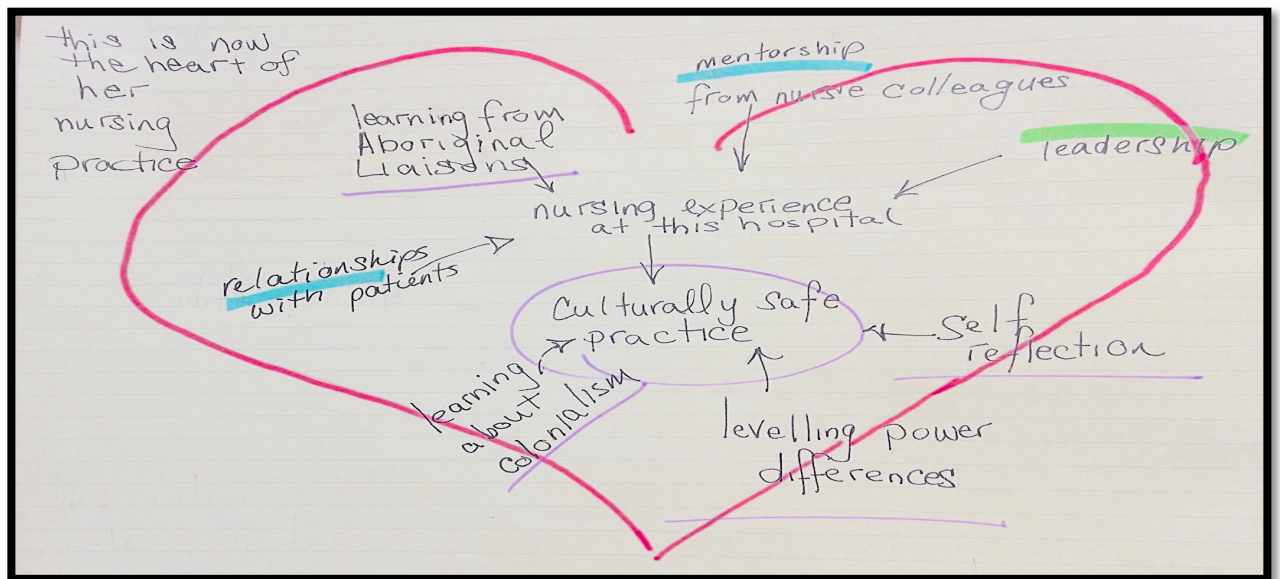


Figure 2B: Situational Map of Interviews 10 and 12



respect for Aboriginal peoples and cultures, I drew a garden (Figure 2B); when other nurses described how speaking up and bearing witness were important to their nursing practices, I included drawings of eyes and mouths in the maps. In one interview, I was so struck by the nurse's narrative of compassion for her patients and her sense of satisfaction from connecting with them, that I drew a heart as the central graphic in the messy map for that interview (Figure 2C). As stated above, colonialism emerged as a key organizing discourse during data collection and analysis, and is visible in many of the situational maps in this study, including Figures 2A (above), 2C and 4 (p. 65).

Figure 2C: Situational Map of Interview 8



Constant comparison requires that researchers compare interview transcripts and move continually back and forth between the data and analysis as they progress through their data collection (Clarke, 2005). During my study, I began comparing interview transcripts after my second interview had been transcribed and continued with this process during data collection and analysis. For example, after I had finished transcribing

my second interview, I made a new ordered situational map to compare the data of the first two interviews (see Figure 1B, p. 50). Comparing this map with the map I made during the planning phase of my research (Figure 1A, p. 50), it is visible that I had turned my focus away from specifying the actors and actants in the maps, to focus on the dimensions of cultural safety as well as the discourses and sociocultural conditions evident in the participants' interviews. In Figure 1B, for example, it is also important to note the presence of the discourse *colonialism*, which had emerged from the data of the first two interviews. Also present in this map is the discriminatory label "frequent flyer" which was not in my pre-data collection map; although I did not know of its importance at this stage, the frequent flyer label would emerge as an important condition in my study as I progressed through data collection.

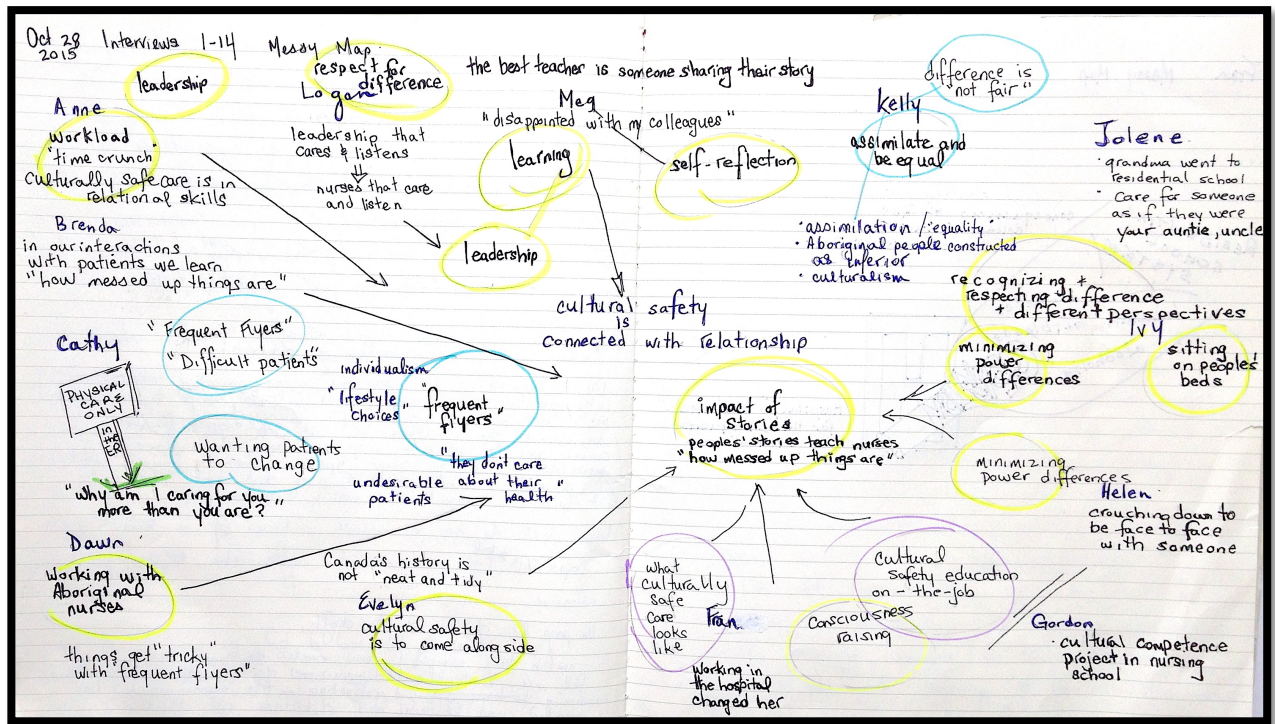
Clarke (2005) argues that discourses themselves are a kind of social arena or social world, and that by going back and forth between the social world and the discourses during analysis, the researcher can interrogate and deconstruct the situation to find new insights. To make the discourses in the nurses' narratives explicit, I would write them out in block letters if they were overt, and in lower case if they were covert or unrecognized by the participant. Clarke also maintains that the conditions specified in the maps needs to direct the researcher to explore how the conditions make themselves felt, and suggests that the researcher ask numerous questions of the data and discourses in order to engage in a deep analysis of the situation under study. To do this, I referred regularly to the group of questions suggested by Clarke (2005) to probe my data (see Figure 3, p. 64).

Figure 3: Questions to Guide Situational Analysis (Source: Clarke, 2005, p. 187-188)

What are these data about?
What are these stories of?
What is going on here?
What are the discourses in this situation?
Who (individuals/groups) is involved in producing these discourses, with regards to support, opposition, providing knowledge, materials, money, etc.?
What and who do these discourses construct? How?
What are they in dialogue about? Who are they dialoguing with?
What material things are involved in the discourse?
How are they constructed? How do they construct the people in the situation?
Who is in the situation and what do they have to say about it?
Who or what isn't in the situation?
Are the discourses symbolic historically or culturally?
What job are these discourses doing?
Are there issues of debate in the discourse? What are they?

As another example of my use of mapping and constant comparison in analysis, after I had transcribed and created situational maps for my first 14 interviews, I created one large map. I began by writing all of the nurses' pseudonyms around the outer edge of the map; next I drew circles containing significant dimensions of their interviews close to their pseudonyms; at the centre of the map I drew circles around the recurrent codes that had emerged up to this point in my data collection and analysis, and these included leadership, cultural safety, relationships and the frequent flyer label. Between the nurses' names and the codes I wrote down the discourses present in the transcript, and I used blue ink to make the discourses explicit and stand out on the page. I also layered in short, pithy quotes from some of the transcripts to show how some discourses were being expressed. As I made the map I added lines to graphically illustrate the connection between the discourses, conditions and codes. Creating this map helped me to conceptualize, in one graphic representation, what my data "looked like" (Figure 4, p. 65).

Figure 4: Interviews 1-14 Situational Map

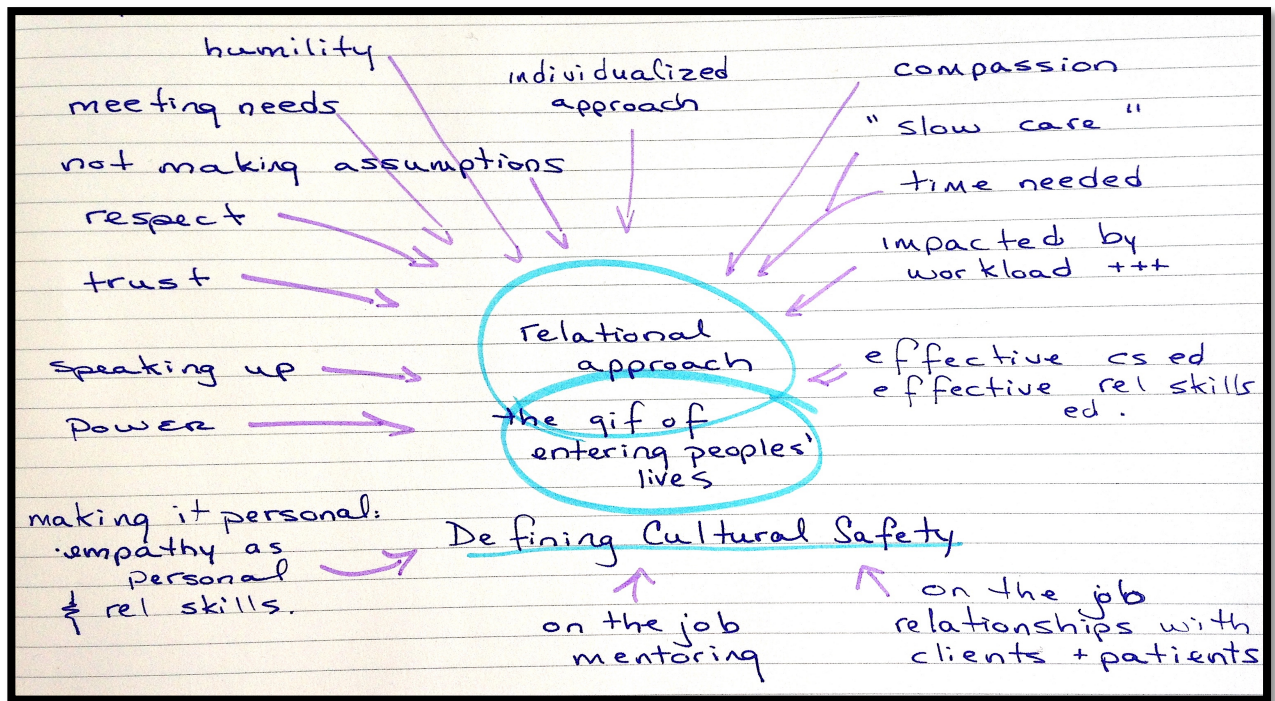


I also used mapping to understand the nurses' construction of cultural safety in my data. After I had transcribed my interviews and created situational maps for each of them, I knew that there were shared dimensions of cultural safety that cut across the interviews, and I wanted to pull these dimensions out of the gestalt of each interview. To do this in SA, the researcher brings the dimensions of a particular element of the situation into relation with each other in a single situational map; Clarke (2005) calls this process relational analysis, and the actual procedure of relational analysis can be tailored to suit the working style and the preference of the researcher. In my process, I selected quotes from the transcripts where the nurses described or defined cultural safety. I then printed these quotes on card stock and cut them out into individual strips. I chose one word or short phrase to summarize each quote, and then wrote this word over the quote using a highlighter. This process revealed several subcodes so that I could create groupings of the

quotes. I arranged these groupings like the spokes of a wheel on the floor, all pointing to cultural safety in the centre. I used this cardstock construction on my floor as a model for the situational map that I drew of the concept of cultural safety (Figure 5). This map, in turn, helped me to “see” the dimensions of cultural safety that I would address in my first data chapter. Please see Appendix E2 for an example of relational analysis from Clarke (2005).

Figure 5: Relational Analysis of Cultural Safety Using Situational Map

Legend: cs = cultural safety; rel = relational; ed = education



Writing

As I prepared to begin writing my data chapters, I read *Writing your dissertation in fifteen minutes a day* by Joan Bolker (1998). Bolker confesses in her introduction that she chose her title to be catchy, that actually writing a thesis in fifteen minutes a day is

not possible. However, I found some of the advice in this little book to be very helpful and motivating, especially when the immense task of actually writing my thesis threatened to overwhelm me. Bolker recommends daily writing, and that students sit down to write at the beginning of the day, before engaging in any distractions; she calls this strategy “write first” (p. 18) with the focus of just writing without worrying about spelling or grammar or content. This strategy resonated with me, as I had discovered during my doctoral course work that writing with pen and paper was the easiest way for me to get my thoughts flowing, without the distraction of the computer underlining misspelled words in red or fragmented phrasing in green. I had purchased a set of lined notebooks for this purpose, and found that my morning writing sessions were often periods of discovery; early in my doctoral studies I had read Laurel Richardson’s chapter, *Writing: A Method of Inquiry*, in Denzin and Lincoln’s *Handbook of Qualitative Research* (1994 edition), and had been making use of writing for inquiry since that time. Bolker also recommends that students finish one day of writing with an idea for where to begin the next morning; she calls this strategy “parking on the downhill slope” (p. 96). Furthermore, when I felt blocked, I wrote about being blocked, using Bolker’s strategy to explicitly interrogate what was getting in the way in concert with Clarke’s questions to guide situational analysis (in Figure 3, above). I found these strategies worked well for me and grew easily out of the process of making field notes, mapping and analysis that I had been working with as I collected and analyzed my data. It was during one of my “write first” sessions, for example, that I discovered and planned out how I would go about a relational analysis of cultural safety using a situational map, described above.

Conclusion

In this chapter I have discussed how postcolonial theory provides the theoretical framework for my study and informs my standpoint as a researcher as well. I have also described how Grounded Theory served as my methodological framework and how I used Clarke's Situational Analysis to guide the analysis of interviews with my participants. Included in this chapter are some of the situational maps I created in the analysis of my data, to illustrate how I used map-making to reveal and amplify important dimensions of my participants' interviews, including the discourses present in their narratives. As a whole, this chapter reveals how I have combined postcolonial theory, GTM and SA to examine cultural safety and racism in the practices of 20 Canadian nurses. This chapter, together with my introduction and literature review, lay out the field of inquiry for the following three data chapters.

CHAPTER 4

CONSTRUCTING CULTURAL SAFETY

In this chapter I discuss how the nurses in my study have constructed the concept of cultural safety intellectually and in their practices as nurses. As described in the methods chapter, all of the participants were asked during their interviews how they would define cultural safety in the context of their nursing practices with Aboriginal patients. It is worth pointing out again that the majority of the participants in this study were early career nurses with less than five years since graduating from their nursing education program and experience working as a nurse in Canada. The early career nurse (ECN) was chosen as the focus of this study so that the experiences of these new practitioners working with Aboriginal peoples and their reflections on cultural safety education could be used to inform nursing education. However, as data collection progressed, it became clear that the perspectives of more experienced nurses could add insight on the context that supports culturally safe nursing practice, especially if they had been working in the north in settings where their work involved service to a significant population of Aboriginal peoples. As a result, seven nurses with ten or more years of experience working in rural areas of northern Canada were interviewed as part of this study. These nurses are referred to as experienced northern nurses (ENNs).

In this chapter, the early career nurses and the experienced northern nurses construct cultural safety in much the same way, and in the discussion that follows, I demonstrate that relationship is a unifying frame for all of the nurses' descriptions and

narratives of cultural safety. What emerged from the data is the conception of a relational practice, with specific and shared dimensions between the experienced and novice nurses working in both hospital and community settings. A discussion of the dimensions of this relational and culturally safe practice will serve as the entry point for the discussion in this chapter. Nurses' relationships at work are also important and often transformative sources of learning about cultural safety; these relationships, and the important learning that they provide, are discussed in the second half of the chapter.

Core Dimensions of Cultural Safety: Respectful Relationships

As discussed in chapter two, colonialism marred the relationship between Aboriginal and settler peoples; therefore cultural safety focuses on healing the relationships between the two communities. For nurses, this means entering into respectful relationships with their Aboriginal patients, and the nurses in this study often explicitly use the word respect to describe their understanding of cultural safety. As discussed in the literature review, respect is one of the core dimensions of cultural safety. One of the simplest and most straightforward definitions of cultural safety provided in my study came from Dawn, an early career nurse with one year of experience working in a rural hospital in northern Canada: "To me it [cultural safety] just seems like a synonym for respect, respecting the individual, where they're from, their perspective on life, what brought them there and how they see the world." Evelyn, another early career nurse, explained that cultural safety is when "The client feels safe to express who they are and also to know that their beliefs will be respected" Evelyn went on to say,

I feel that cultural safety, in a nursing context, is creating a space for relationship and interaction where the patient or client feels completely comfortable to be themselves in the full respect—backgrounds, religious values, and anything like that—and also feels comfortable to be themselves or express themselves in that respect, because they know that those values and ideas and their own personal take on things are respected—and that there is an understanding that that’s important to the care provider, in terms of respecting that with the patient.

From the narratives above, it is clear that Evelyn and Dawn are both defining cultural safety in the context of respectful nurse-patient-relationships; also, in joining cultural safety and respect together, these early career nurses are indicating that spending some time with their patients in order to get to know them is what makes a respectful and culturally safe practice. This link with the nurse-patient-relationship and the importance of time in the development of these relationships is a theme that runs through the nurses’ definitions of cultural safety, regardless of whether the nurse is early in her career or more experienced. Many of the nurses also identify specific relational skills, such as listening, showing empathy and developing rapport when they describe what cultural safety looks like in the context of their relationships with Aboriginal patients. For example, Anne, an early career nurse in the first year of her professional practice states, “Cultural safety is part of compassion, it’s being empathetic and listening. It’s thinking, ‘What’s going on here? What are the roots of what I’m seeing here?’” Jolene, an experienced northern nurse who is currently providing home care in rural Aboriginal communities put it this way:

We take on a little bit of new grads and I always think to teach them to listen to the patient, and then do the treatment. It’s really important to sort of build up a rapport with the patients first, and then say, “Okay now I’m going to give you your injection, or now I’m going to do this.” I think it’s big to get comfortable with them first, especially in home care.

In these nurses' narratives it is visible that their understanding of how to provide culturally safe care requires time spent with patients and clients, either for listening and developing rapport, or explaining treatments, medications and procedures. However, as discussed in chapter two, a nurse's time is often constrained, especially in contemporary hospital environments, and a common challenge for new nurses as they transition from student to practicing professional, is time management. As the following statements from early career nurses demonstrate, the workload in contemporary hospital environments is seen as a significant barrier to the provision of culturally safe care:

I mean, there was a smudging room, and there were other really innovative programs offered at the hospital, and even me, I'd feel so rushed and frantic, and then one of the patients wanted to go to the smudging room, and I'd say, "great I'll get you ready," but I remember thinking that that was just another thing on my workload, and I felt pushed to the limits. So I think you need manageable workloads to provide compassion and empathetic care, and culturally safe care. (Anne, ECN)

Being able to listen to a full person's story and take the time to sit down and really listen is really difficult if you're running around and trying to get a million things done at the same time. But, that being said, I feel like when you do take that time out and have true relationship building kind of conversations, the patient care is seen as much better—you have a better relationship with that person, they respond better to you, the overall atmosphere is more positive. (Ivy, ECN)

I tell you, when you're looking at the beginning of the day, who's the most acute, who's this-and-that, and the needs of all those people are profound and they're so different, that cultural safety sometimes, like you just, I mean you, you try to give safe care but you don't always have time to go at the speed that someone might want, or to explain it as thoroughly as they need it to be explained, right? (Frances, ECN)

These early career nurses, all of them working in hospital settings, are acutely aware of the tension between the time required for the care they'd like to provide, and the workload demands of their hospital jobs. As discussed in chapter two, a value is placed

on nurses' efficiency by hospital management and senior nursing staff, and many new nurses often evaluate themselves based on their ability to manage their workload and "carry their weight" on the nursing team. The nurses in this study, however, clearly value the time spent with patients, even though the workload and time constraints of the hospital context regularly interfere with this dimension of their practice. First Nations organizations also place a value on nursing time spent building relationships, and expect that the nurses working in their communities will spend time with their members. Jolene, an experienced northern nurse currently working as a home care nurse for a First Nations organization, highlights this difference between hospital and community nursing by relating her experience trying to train a nurse who has just transitioned from the hospital to the community:

One of the new staff that I started training was really having problems. She said, "Oh, I never know what to say!" And some of the clients were saying, "Is she ever rushed when she comes here!" So I told her, "You need to just sit down and say, 'How are you doing?' Talk about the weather, or ask, 'How's your family? Where'd you grow up? Are you from here?' Or in the summertime, 'When's the Pow Wow coming up?' Because all of the communities have Pow Wows and they like to talk about the Pow Wows. And the nurse said, "Oh, okay." So she started doing that and I think it really helped, because after that I never heard the clients saying, "Oh, she's so rushed!"

Now that she has been working as a community health nurse for five years, Jolene reflects on the pace of work in the hospital. It is clear that she now views building relationships with her Aboriginal clients as central to her effectiveness as a nurse:

Looking back now, if I could go back now into the hospital I think I would be more patient and get to know an Aboriginal person first, instead of being so task orientated. I worked in the hospital for five years, and you're always thinking, "Okay let's just get this done, next, next, next!" Whereas in community nursing it's more about teaching and building up that relationship so you can help them further.

Sam, an early career nurse currently working in an urban emergency department, also identifies building relationships and developing rapport as central to his nursing practice:

It's definitely the relationship part that matters a lot... I try to find out more about them. It's like I said at the beginning—it's not really about the technical skills, it's about building the relationship. So maybe the next time I see them, I can say, "Hey!" and call them by their first name, and ask, "What happened?" It makes it easier if I know them, have built a relationship with them, and have built that rapport from the beginning.

As discussed in chapter two, clear communication between patients and health care providers has been recognized in the literature as an important dimension of cultural safety, and previous research has identified that being listened to regarding their needs by their health care providers is important to patients' perceptions of cultural safety. In the present study, many of the nurses identified that taking the time to ensure that their Aboriginal patients understood the care that they were providing was part of how they understood culturally safe care as well: Jolene, reflecting again on her work in the hospital at the beginning of her career, talks about the importance of spending time explaining things to Aboriginal patients:

I think it would have made their care much better if I would have been able to, you know, explain—not that I didn't explain, but...just knowing what I do now, I think I would explain, not necessarily in simpler terms, but really *over* explaining even.

However, as Fran explained above, spending more time explaining things isn't always possible, given the workload demands of contemporary hospital environments. In the next exchange, Cathy, an early career nurse with three years of experience as an emergency room nurse, describes her struggle with the pace in the busy urban hospital where she works:

Cathy: I think that's the hardest part, is sometimes I feel like I'm not doing what I'm supposed to be doing

Researcher: What are you supposed to be doing?

Cathy: How I treat them, how to make it a better experience for them, as much as I try to be as positive and compassionate and understanding, there's also a limit on what I can do. Sometimes I have the luxury of being able to do that and sometimes I don't.

In this quote, it is clear that Cathy has not stopped wanting to spend time with her patients, despite three years of experience working in a fast paced environment: time spent with patients is clearly an important dimension of how Cathy and the other nurses in this study understand respectful relationships and culturally safe practices.

Nurses in this study also link their understandings of cultural safety with not making assumptions about patients based on their membership in a cultural group. Just as cultural safety happens inside the interactions between nurses and patients, cultural safety also requires that nurses get to know their patients individually, to learn about their individual preferences and partialities, and most of all, their needs. As Brenda states quite simply, "It's [cultural safety] not making assumptions about people and what their needs are." Many of the early career nurses in this study talked about this dimension of cultural safety. Ivy, for example, explained this understanding as a moving away from stereotypical thinking:

In our hospital we have lots of Aboriginal patients and cultural safety is really what the person themselves expresses of their needs and their importance and their values. Even if people are from the same area and the same background, they all place their culture and all of that stuff in different priorities. So it's really focusing on the person themselves and how that person prioritizes what's important to them. I've found that people from the same region, they should all be similar, and they're not necessarily. So really focusing on that individual and all of that. There can be five people from one group but they all see things entirely differently.

In the next quote, the term respect emerges again, but this time Meg uses it to refer to the importance of not making assumptions about an Aboriginal patient's culture and cultural practices:

I think the biggest thing is respect, that the patient feels respected. I don't have to know everything about their culture. I don't have to understand everything, but I have to respect that it's theirs. I just have to have an awareness, and there's nothing wrong with asking.

Meg, a nurse with 20 years of experience working in the north, suggests that she has learned that the wide diversity of Aboriginal cultures makes it impossible to know all there is to know about each one, but that patients are receptive and comfortable when nurses ask them questions. In the following segment, Jolene talks about how she shows respect for the traditional healing practices that she encounters as a home care nurse. Part of her respectful approach also involves asking questions:

Lots of times we'll go in and they'll have cedar taped to their leg, or they're soaking their feet in cedar...and I'm not going to say, "You need to take that off and put this bandage on." Instead I say, "Why don't you try that and if it doesn't work in a week, maybe we'll try this different product. And I always ask, 'How is that working, what is that doing?' And sometimes it does work, not always, but being accepting is big.

Early career nurses explained that asking questions was important to their approach as well. Ivy, for example, described how she was taught this approach during her nursing education:

I remember one class and we had someone come in specifically to talk about racism and culture and all of that stuff, and just kind of putting the spin on it that we never know and it's okay to ask questions and be inquisitive and try to really get to know what's important to that person.

Nancy, an early career nurse currently working in an urban pediatric ICU, shared that asking questions is an important part of her approach as well:

I like to learn about everything, so if they are interested in telling me, then I ask lots of questions. I just like to learn and make it an open conversation. And families are happy to tell me most of the time.

As many of the nurses in the current study shared, avoiding assumptions is important to culturally safe practice. Dawn shares why not making assumptions is so important in the rural hospital where she works:

It's challenging here, because you don't necessarily know who's Native and who's not. You just can't tell all the time, because up here it's been mixed a lot, so there's a lot of people who just look like a Caucasian person, and then you find out that they're actually First Nations, or that they have very strong ties to [name of Aboriginal community], and you would have no idea based on just seeing them and listening to them talk. So you almost have to go in with that approach, because you don't know.

Brenda, an early career nurse, ties in the importance of not making assumptions directly with her conception of cultural safety. For her, cultural safety includes having an appreciation that each individual's life experience influences his or her perspectives on his or her health:

The essence of it is understanding that there are many ways to understand the world, depending on what cultural perspective you're coming from, and that if you can keep that at the forefront of your mind when you're interacting with people then you cannot make assumptions about them, not make judgments about them but try to understand that their life experience is informing the way that they're understanding this health problem.

These nurses, in highlighting the importance of showing respect and avoiding making assumptions about their Aboriginal patients, demonstrate a respectful and purposeful curiosity. They emphasize that in order to meet a patient's needs, a nurse needs to get to know a patient and find out what those needs are. As discussed in chapter two, this stance is reflective of current thinking in self-management support and trauma-informed practice, which are collaborative approaches that involve getting to know

patients, their priorities and perspectives. As Fran explains, “If you don’t function within the grounds of cultural safety, you’re not going to be very effective, for the most part.”

Engaging in a respectful curiosity with patients and families regarding their cultural healing practices allows nurses and other health care providers to discover what is important to that particular patient and family, as well as the variations within cultural groups. This approach is essential to acknowledging the rich diversity of Aboriginal cultures, and the recognition of within-group differences also helps nurses to avoid making assumptions about their Aboriginal patients and clients. As discussed in my literature review, the dominant approach to working with difference in health care is cultural competence, and this approach reflects colonial discourses in our society, in that it encourages providers to learn about the cultural differences of each group. Logan, an experienced nurse who trained in the 1990s, described what he learned in nursing school:

My transcultural concepts was really varied. There were some points from each ethnicity of how you deal with these people, verbally and nonverbally, and respecting things. But [Aboriginal cultures] was almost a subpart, it was like, “Oh and we have First Nations people.”

Transcultural nursing was the pre-cursor to the term cultural competence in western medicine, and bloomed in nursing education in North America in the 1980s and 90s. In Logan’s quote above, it is visible that the transcultural approach he was taught focused on key differences between cultural groups, and erased from view the rich diversity among all cultures, including Aboriginal cultures. This feature of cultural competence is a key source of its critique in the scholarly literature. However, as discussed earlier, cultural competence continues to be a part of the nursing curriculum in many nursing schools. When I asked Gordon, for example, to describe the approach to working with

difference that he learned during his nursing education, he described a project that is consistent with cultural competence:

I recall doing a project on the Japanese culture, and what their habits were. In my Japanese project, they [Japanese people] often close their eyes and we explained that it might be interpreted as impolite, but [it is] actually them making an effort to listen intently. So they might look down and close their eyes, and you could assume that they are ignoring you when in fact, they're listening.

In this project that Gordon did with student colleagues, the underlying assumption is that all Japanese people close their eyes when listening. However, as Nancy stated in her interview, "If you just read about every single culture and what they do then you kind of pigeonhole them into "All Jewish people do this," or, "All Aboriginal people do this," and that's not the case at all! Some Aboriginal people don't follow traditional ways; some of them are Christian."

However, given the Pan-Aboriginal discourse and stereotypical representations of Aboriginal peoples that continue to be widely circulated in Canadian media and society, making assumptions or stereotyping is a common trap for health care providers. For example, although the quotes included from Nancy's interview above indicate that she asks questions and recognizes that there are many differences among Aboriginal people, one of her statements reflected this common assumption:

They're very reserved these parents. It's very typical, like avoiding eye contact. They're shy, and they're not going to say much, right?

As discussed earlier, this culture-based understanding of difference is often termed culturalism in the literature, and my intention here is to demonstrate that dominant

discourses and assumptions can and do influence the perspectives of many nurses, including a thoughtful nurse like Nancy who is attentive to cultural safety.

As discussed in literature review, the Maori community developed the model of cultural safety as an answer to what was needed to address Maori peoples' dissatisfaction with mainstream health care services; cultural safety is actually a translation of *Kawa Whakaruruhau* and involves learning about colonialism and self-reflection on the part of health care providers. Underpinned by the theoretical framework of post colonialism, the model of cultural safety asserts that without this knowledge, health care professionals lack empathy, which is at the heart of the discrimination experienced by Aboriginal peoples in mainstream health care. In the following narrative, Logan, in describing his relational approach as a community health nurse, is very cognizant of the discrimination his Aboriginal clients experience when they access mainstream health care:

I address needs. I think about what that person is here for and listen to them. I'm not reinventing any wheels, I'm just listening and I get that that something is built between us. I think of it as trust, so I guess relationship and trust are something that can be attached together. They trust me. I don't let them down. That's how they often feel, like they're let down, or that they're not important.

As discussed in the methods section, the participants of this study shared their experiences working in hospitals and communities all across Canada. Regardless of the region or setting where they worked, many of the nurses described encountering racism and negative attitudes towards Aboriginal peoples in the health care system. When asked about the attitudes that she had encountered towards Aboriginal peoples at the hospital where she works, Dawn replied, "...generally at [name of hospital] I think that there is definitely a lot of cultural awareness in terms of First Nations people...but there's still

definitely some not-so-great attitudes, but that's everywhere." Evelyn describes her experience working in a rural hospital northern Canada:

I did not regularly experience culturally safe care for the patients, particularly of Aboriginal descent, which was a large population in that area. It would be very obvious in the comments that nurses would make, not directly in front of the patients, but certainly among the other nurses. At one point this even included the supervisor who was making such comments. I really took a step back while I was there, and didn't really say much, but I kind of took a lot of that in, and just saw that for the most part, there was a lot of negative attitude towards Aboriginal Canadians in the health system, and just Aboriginal issues in general: where taxes are going, financial things, just all sorts of different attitudes that were very, very prevalent.

From Ivy's perspective, the racism at the hospital where she works is due to a lack of education. As she described in her interview, "There is a whole ton of racism that I don't think is an intentional thing, it's a naiveté, kind of thing." As she explained further:

Aboriginal people get free ambulance rides to the hospital, to get treatment, and we put them up in hotels because they're too far away. There's a lot of resistance to that; people [staff] are upset that we are willing to put people into a hotel and pay for it and a lot of that stuff for certain people but not for other people.

Ivy goes on to explain how her understanding of the impacts of colonialism and an awareness of trauma informs her empathy towards the First Nations people in the rural area where she lives and works:

The entire group itself is low income. A lot of that stuff is because of colonialism, residential schools, intergenerational traumas, and I think that there's also a lot of drug abuse in the area as well. So I think all of that stuff combined has created a kind of a negative living scenario for people. That's a very difficult life, and it's hard to get out of that difficult life once all of those things have compounded and made the person's living situation a very difficult one...and all of them are kind of intertwined. It's many, many, many things that have created a very difficult living scenario for someone who is now in a dangerous situation for their health. I think sometimes that doesn't get seen as much from some of our other staff members, that all of these things combined have caused that person to now be in this scenario. Versus some people [staff] who will say, "How could you have let it get that bad?"

Learning about colonialism and its impacts on Aboriginal peoples also counters the widespread silencing of colonial history in Canadian society. In the following passage, Meg talks about what she has learned about intergenerational trauma and the resistance to this learning that she encounters in the rural and mostly white community where she lives:

One of the other things I thought of as well that I wanted to share is the impact of things like the residential schools—definitely the abuse, just a lot of things—and it's happened in our communities and in our area and it's generational. People here say, “Why are they complaining about the residential school? It wasn't them—they're only twenty-something years old! Why do we have to feel bad for them for that? They didn't experience that.” But what they don't realize is that the way that they were parented or the support or lack of support they had from their parents was directly from their parents who did experience that, or their grandparents, or you know, how the community was sort of broken. And that's something even myself, I have very little understanding, like I'm learning more and more about it. There's very little knowledge there. And I think people don't want to hear it.

Here, in sharing what she has learned about intergenerational trauma, Meg is also unpacking how a lack of knowledge and understanding about the impacts of residential schooling is related to a lack of empathy. As we talk further, Meg shows she believes it is important for nurses to be open to this learning, in order to show respect for their Aboriginal patients and for the profession of nursing as well:

I find it disrespectful, it saddens me. I try to share what I know and what I've learned, but I think they've got sort of a pre-established idea, or they just don't want to know or learn or care. Which saddens me, because that's not why we're in nursing.

In the face of such intolerance, what makes for effective cultural safety education? Meg, an experienced northern nurse, shares her opinion:

What I have found effective in the past, is that an Elder coming—someone who came to the hospital—I arranged it. And he talked about his experience...and it didn't have to be an 8-hour paid education day. He spoke for an hour and a half. We had it in the boardroom, an open lunch and learn thing, and you know, we gave him an honorarium to present. And we asked him to talk about what the residential school was, and what his home life was. And he was so positive. He said, "You know what? It was really hard but I persevered. I made it through, I'm okay, but I just need you to know this is why I am the way I am. Now my brother didn't do so well..." And he talked about his kids and his grandkids and the impact that his experiences have had on them.

In this kind of a presentation, the people gathered enter into a relational experience with the person who is telling their story. This is experiential learning, which, as discussed in chapter two, has a large body of evidence behind it that demonstrates its effectiveness in social justice education. When I asked Rachel, an experienced northern nurse, what had made the biggest impact on her learning about colonialism, she was overcome with emotion as she recalled some of stories her patients had told her about residential school:

I think that you can't feel it if you just read it. I have learned more from the people who actually lived it than from all of the research papers I have read. And that is what makes the impact. Like the Truth and Reconciliation Commission, they actually had people standing up and telling their stories, and that is how I think most of us can make the connections.

Several early career nurses spoke about important learning from their nursing education that deepened their perspective on the root causes of the poor health status of Aboriginal peoples. As Cathy shares, learning about residential schooling and intergenerational trauma during her nursing education is something that has stuck with her:

In the nursing program I remember there was a lot of talks and I remember your class on the Aboriginal, and learning about how many Aboriginal people are perceived in a negative light, for example, that they are "just coming in for food," or that they are misusing resources and stuff like that—and then you showed us the flip side of why they are doing it, to understand their background, like the

residential school, all these things that we might think happened so long ago that it shouldn't affect these people, then seeing why it still affects people generations down the road—I think that's the thing that really stood out for me.

Evelyn shared that what she learned about colonial history in Canada during her nursing program addressed the gap in her understanding from her public education:

I remember in grade six or seven learning about Canadian history...but in retrospect I don't feel that I got a good picture of what had gone on, in terms of atrocities that happened and things like that. There certainly was an understanding that Aboriginal Canadians were here first, and the settlers and military came after, but the history wasn't accurate to what I learned later on in the nursing program. Although I remember learning about wars and acquisition of land, I don't remember too much, but I remember it just sounding a lot nicer than what I learned later on. We learned a bit about things [in public school], but it was very "neat and tidy."

For Jolene, in contrast, the residential school was a backdrop to her childhood experience growing up in a small town in northern Canada:

The residential school here was just across the road, and my great-grandmother went to it, so that maybe is why I'm more aware of it, because I knew it was over there.

As Jolene illuminates, her empathy for Aboriginal people is personal. When asked how she understands cultural safety, Jolene explained:

So I'm Status, so I'm Native myself, so I grew up around it. My grandma doesn't live on reserve, but I'm sort of familiar with some of the Native stuff, some of the cultural things...and I just think it's a different culture; it's such a different approach. And I always felt that in the hospital when Native people came in, especially if they didn't speak the language, they almost didn't get the same sort of care. And when a little Native lady would come in, they always reminded me of my grandma, so I'd always spend that extra time with them and that.

Dawn describes the positive impact that working with Aboriginal nurses has on her and her nursing colleagues:

We do have a handful of First Nations nurses. So I think that also really disables people from being really overtly racist, 'cause you can't, because it's your team, right? And they're exceptional nurses and really great people. So I think that that's always the reality that people [nursing colleagues] are seeing both sides of the spectrum and not just the negative stereotypes are perpetuated.

As Dawn clearly states, being able to work with Aboriginal nurses has had a positive impact on her perspective, as well as on the attitudes of the team of nurses that she works with. Unfortunately, the persistent shortage of Aboriginal nurses in the profession makes Dawn's experience uncommon. As discussed in the literature review, Aboriginal nurses still account for less than one percent of the profession, despite the call for action on this issue identified during the Royal Commission on Aboriginal Peoples in the 1990s; as the recent TRC report shows, the negative impact of the Residential School System on education is largely responsible for this shortfall.

Relational Practice and Transformative Learning

For nurses with an awareness and understanding of the impacts of colonialism, working with Aboriginal patients as part of their nursing practice can be an important and transformative opportunity for learning and deepening of empathy. In the following narratives, Helen shares how her relational skills have developed on the job as a nurse working in a rural hospital in Canada's north, where approximately fifty percent of patients are of Aboriginal ancestry. In one vignette, she shared that a nurse colleague told her that many First Nations people really value eye-level communication: "So I started making that a part of my practice with just First Nations people, and then I realized that it became part of my practice with everyone, and my communication with everybody

changed.” This learning experience transformed Helen’s practice, and it also demonstrates how a culturally safe approach can grow out of attention to relationships. Helen explained that communicating at eye level has added an emotional depth to her nursing work:

When I think of the things that people have shared before they died, or the things that they have told me that they haven’t been able to tell their family—that’s really intimate. When you can get down with someone on their level that can make such a huge difference in the way they communicate. For me, learning that was amazing. That changed me.

When I asked, “What do you think getting down at eye level with a patient who’s in bed—what do you think that signifies?” Helen replied, “That I’m your equal, and that I’m here for you.” As discussed in chapter two, advocates of cultural safety in the literature describe it as a critical approach that draws attention to power imbalances in health care relationships. Helen’s experience suggests that attending to relationships in her work has indeed helped to draw her attention to power in health care interactions. In a parallel story, Ivy also talked about the important mentoring she received from an Aboriginal liaison worker at her hospital, whose exceptional relational skills drew Ivy’s attention to how she could strengthen her nurse-patient relationships:

I’ve brought her in on a couple of scenarios, and she is phenomenal! Just her presence around patients is really something to model, and to try and take away. She’s very good about being to the point and being very honest, and she is a great listener.

When I asked Ivy, “Are there some things that you try to do in your own practice that you could name?” she replied:

She’s the person that got me sitting on peoples’ beds! She’s very personable in that she walks in as another person, as opposed to a superior nurse or doctor; she doesn’t shake hands like we often end up doing on the professional side. She

walks in and introduces herself and takes a seat on the bed and gives them a hug sometimes. It's very informal and I think that that approach to the scenario opens up the person...as opposed to a position of power in talking to someone.

Just as Helen observed with eye-level communication, Ivy has witnessed how the Aboriginal liaison is able to open up relationships with patients by taking an informal approach that can include taking a seat on patients' beds. Working with this mentor provided Ivy with the opportunity to reflect on how formal "professional" approaches can reinforce power differences. Also of interest for the discussion here is that relational learning experiences at work can provide important cultural safety education for nurses.

Becoming aware of how power operates in health care interactions and attending to these subtle but important elements when relating with patients is also an approach that can disrupt the neo-colonial exercise of power and superior "expert" stance that is commonly assumed by western health care professionals. Naomi, like Helen and Ivy above, also shared that being mindful of body position is an important part of cultural safety and her approach as a nurse: "Cultural safety is being aware of power differentials in health. So if a person's lying in bed and they're staring out the window, I might crouch down so that I can be at eye level with them." For Patty, an experienced northern nurse, attending to her gestures and facial expressions has become an important part of cultural safety in her practice:

Nurse: Micro-aggressions might be like a facial expression or "tsking;" a client might say that they didn't check their blood sugar today and the nurse might go "tsk," which implies "What's the matter with you?" It's little things like that. An Aboriginal person is going to be extremely good at recognizing that...they have to live with micro-aggressions their whole life.

Researcher: One of the papers I read called those things "everyday racism," the little things that a white person might deny.

Nurse: I always try with my gestures and my facial expressions to indicate that I'm not going to say or do anything rude or ignorant. I always try to be aware of it, and try not to do anything that's a micro-aggression. But sometimes I still have little "Oh no moments." But then I just say, "I'm sorry," and just carry on. If people see you are trying that's important.

In the exchange above from my interview with Patty, we talk about everyday racism and micro-aggressions, the subtle and unremitting expressions of racism that often go unnoticed by white health care providers. As discussed in chapter two, it is important to understand that we are all produced by a colonial system that is constantly at work recirculating racist discourses and masking them at the same time; as a result, and as identified by Patty above, trying to avoid perpetuating everyday racism requires constant attention, and remains a possibility even for a reflective and attentive practitioner.

As discussed in chapter two, a dimension of cultural safety that often draws critique in the literature is the emphasis that the final determination of culturally safe care is meant to be made by the patient. As Anne states, "I first learned about cultural safety in the nursing program. I knew about cultural competence before coming into the program, but the idea of safety as being from the patient's perspective was a new one for me."

Anne continues:

I guess the challenge for everyone is translating that into the real life. I mean, how do you know sometimes what you say or even your body language, how that influences how someone feels? They might not let you know, so it's hard I think to understand how to put these ideas into practice.

Fran however, has discovered that trying to unseat the expert stance commonly assumed by health care professionals can amplify patients' voices regarding their experience of culturally safe care: "I think maybe the best thing is humility...realizing that maybe I don't know exactly what safe care is—I think that's a good place to start." For Fran,

humility involves letting patients' perspectives lead, which is an effective way to level the power imbalance between that of her role as a nurse and that of her patients. Naomi described how she puts this aspect of cultural safety into practice:

The client needs to be able to define what safety means to them—so it shouldn't be like, "This is what cultural safety is and this is what I'm going to do for you today." It's, "What do you want out of this encounter, and how can I do that?"

In this chapter I have described how cultural safety has been revealed to the nurses through observing and attending to relationships, and their descriptions of the concept are often framed in terms of their relationships. Many nurses described how knowledge of colonialism informed their observations and vice versa, and how working with Aboriginal patients also adds depth to their knowledge of colonialism. Brenda, for example, in talking about her experience in a small rural clinic, describes cultural safety in terms of her observations of the nurses she has worked with:

The nurses who I would say were more living it had more relationships [with clients]. Like one of them had been working with Indigenous communities for twenty years...and even though she didn't use terms like colonialism or cultural safety, I feel like she just knew from her relationships with people how kind of messed up things were, and was very compassionate and caring as a result.

Brenda is describing that by entering into relationships and listening to the stories of Aboriginal people as part of their work, nurses can learn about the everyday social reality that is lived by the Aboriginal people that are coming to clinic. Fran, who grew up in the north, talks about how working in the hospital has deepened her awareness of the impact of residential schooling on Aboriginal peoples:

The truth is I don't think I ever really fully appreciated the consequences of residential school until I worked in the hospital, because I feel like that is a place where it's like a *bottleneck* (spoken with emphasis), where a lot of these problems, and the results of these problems collect in various health conditions. I thought I

really understood what it was all about, and I thought that growing up here had provided me with this very solid foundation and awareness, but it really wasn't until I had been nursing for two years when I began to fully appreciate the devastation that happened culturally.

These nurses are learning about colonialism and its impact on Aboriginal people on the job through their work as nurses, by observing and attending to relationships, being mentored by culturally safe role models, and trying approaches that level out the power gradient between them and their patients. Their narratives reflect a deepening of their empathy for Aboriginal peoples, an outcome of the continuous learning and reflection that is a part of cultural safety. In the narrative that follows, Fran talks about how listening to the stories of Aboriginal Elders as part of her work as a staff nurse opened her eyes to the strength of Aboriginal peoples:

People will tell you stories when you ask them, or when you listen; often they'll just kind of start talking. We get a lot of Elders and I love working with them. I'm interested in Aboriginal health personally, and I'm sort of drawn to trying to create that safer space for them. Often they just want to tell you stories. So when you have time, it's a really *lovely thing* (stated with emphasis), because you have people who are in their eighties and nineties who were literally born on a sled in the winter near a tree and wrapped in furs. These stories they tell you are a fantastical thing, but they're true. I can't possibly relate to what has changed for them since then, and here they are still carrying on, despite the myriad harms that have been directed at them.

In this narrative Fran is referring to the resilience of Aboriginal peoples that has been revealed to her through her work as a nurse. When I asked Nancy to reflect on how her experience working in a remote community had affected her, she also talked about the resilience of the people:

It was so interesting to me to see how they live and see the poverty, and this is within Canada, right? But then it was also great to see their strength in their community—they had all these events, and Elders teaching crafts, and that is so amazing.

Working with Aboriginal people in hospital settings can also awaken nurses to the depth of the experience of trauma. In this next narrative from Fran's interview, she talks about working with residential school survivors:

I'll often ask the Aboriginal Liaison a bit about the person, because it's an important thing to know when you enter into a therapeutic relationship with someone. I have people, for example that will shower in their pajamas, fully clothed. And when that happens, it changes your sensitivity of it. I suddenly think, "Okay, I'm going to assume that everything I'm doing feels coercive to this person right now, so how can I minimize the harm of that?" You just start to know these behaviors that really identify the trauma that someone's been through; it's very specific and it just changes your whole approach. I mean, when you know for a fact that someone's endured very specific traumas it does change the way you approach the health care you provide.

In this narrative, Fran is demonstrating her application of the principles of trauma-informed practice, which, as discussed in chapter two, are important for nurses working with Aboriginal people. Specifically, the way Fran describes her care of residential school survivors demonstrates trauma awareness and respect for patients' dignity. In addition, Fran's story demonstrates how, by providing respectful nursing care for a patient who is a residential school survivor, she has experienced a profound awakening to the impact of trauma from residential schooling. This account reflects a deepening of empathy and an enhanced awareness of the impacts of colonialism on Aboriginal peoples.

In a similar way, Helen describes a situation where she was under pressure to hastily discharge an Aboriginal patient to relieve a bed crunch: As Helen began packing up the patient's things, the patient became extremely upset and Helen called the Aboriginal Liaison for assistance. It was the Aboriginal Liaison who pointed out to Helen

that packing up the patient's belongings into boxes without warning was associated with the residential school experience:

I could understand that trying to discharge someone on a day that they weren't supposed to be could be unsettling. But throwing everyone's clothes in boxes—that hadn't been a cue for me. But the First Nations Liaison worker said, "Do you understand? This is associated with what happened," and I could totally get that: If someone took all my stuff and started throwing it in boxes, I would be uncomfortable...but if it was associated with a really horrible event in my life? Completely.

In this chapter, I have explored how the nurses in this study have constructed cultural safety in their nursing practices with Aboriginal people. When asked to talk about cultural safety, these nurses have talked about their approach when working with Aboriginal people, and what has influenced its development in their practices. For the nurses, a culturally safe approach is one where respect and relationships are centred, along with empathy, listening and trust. This respect includes respect for human dignity, as well as Indigenous knowledges and healing practices. To build this approach in their practice, these nurses are entering into the lives of Aboriginal people through relationship. As Meg, an experienced northern nurse says, "the career for me is one in which I feel honored to be part of someone's life. It's a gift that you can enter peoples' lives." Through relationship with their Aboriginal patients and clients, these nurses have learned and continue to learn about colonialism and reflect on their practice, which is what cultural safety is all about. In the final quote for this chapter, Logan shares his hope that more of his nursing colleagues will adopt this approach:

You know, I sometimes wonder if you were to corral a bunch of practitioners that work like I do, that it would be a pretty slim bunch—it's how I feel some days. Because it just seems like, “How come nobody else...why do I get this feedback from my clients about how they're treated? Why? Why, why, why?” It's always the question, and it ends with, “Why?” I just long for the day that it stops being a question.

As this quote suggests, Logan's perception is that a culturally safe approach is not commonplace, and many of the nurses in this study expressed a similar sentiment. During interviews, I asked participants if they could describe an incident that they had witnessed where an Aboriginal person might not have felt safe, and what factors they thought had contributed to their discomfort. In the next chapter I will share these nurses' stories of culturally unsafe practice in the health care arena and their attempts at decolonization.

CHAPTER 5

DE/CONSTRUCTING RACISM

In chapter four, I presented my findings on participants' construction of cultural safety. I argued that the nurses' narratives illuminate a relational practice, one in which cultural safety is understood and experienced in the context of respectful relationships with Aboriginal peoples. In the literature, it is underscored that learning about colonialism is meant to develop empathy in health care professionals; consistent with this view, I used examples from my data to illustrate that the nurses' respectful relationships often deepened their empathy and provided a profound awakening to the impacts of colonialism. In short, an examination of the construction of cultural safety revealed it to be a relational concept, one that is both experienced in relationship and enhanced through relational learning.

As discussed in the literature review, scholars position racism at the heart of colonialism and colonial practices in Canada. When racism is acknowledged in this way, it becomes visible that learning about colonialism is in fact learning about racism, including epistemic and systemic racism. As discussed in chapter two, epistemic racism in health care is about positioning biomedicine as superior and dominant, as well as regarding Indigenous Knowledges and healing practices as inferior; systemic racism is about policies, such as the Indian Act and the residential school system, that continue to heap an unfair burden of poor health on Aboriginal peoples. Racism at the systems and epistemic levels is enacted in interpersonal relationships, and in this chapter I will focus

on racism at the interpersonal level, as experienced and described by the nurses in this study. Given that racism toward Aboriginal peoples in health care is maintained and perpetuated by colonial ideology and discourses, an analysis of these discourses will accompany the discussion throughout this chapter.

Colonial Discourses and Discriminatory Labels at Work

During their interviews, the nurses in this study described interpersonal racism in the context of their relationships with Aboriginal patients and clients, as well as in their relationships with other health care providers. Whereas the descriptors of culturally safe care from the last chapter include respect, listening, trust, taking time and patience, the nurses' accounts of interpersonal racism in this chapter describe interactions where patients are ignored and care practices are hasty and impersonal. To begin, I will revisit Logan's comment cited at the end of the previous chapter:

You know, I sometimes wonder if you were to corral a bunch of practitioners that work like I do, that it would be a pretty slim bunch—it's how I feel some days. Because it just seems like, "How come nobody else...? Why do I get this feedback from my clients about how they're treated?"

In this quote, Logan reveals that he sometimes feels alone as a culturally safe practitioner in his area, and this is based on reports from his clients. Other nurses in this study have also had patients confide in them in this way; Patty, for example, an experienced northern nurse who visits remote communities to provide diabetes education, stated, "I hear the stories from the people. People know right away that I'm not like those other white people, and they will tell me what happened when they went to the nursing station."

As discussed in chapter two, rural communities often have particularly limited options for primary care services, and choices for remote communities are even more constrained. For Logan, this means that if his clients need to see a physician, they need to go to the local emergency department. As a result, he spends a lot of his time as a community health nurse providing assessment and home care advice, so that his clients from the rural First Nations community where he works, in his words, “don’t have to go into town to sit for eight hours in emerg to not get treated.” As he explained:

They sit there and they’re not part of the communication loop; nobody comes out to say, “Hey, we’re backed up,” or, “This is what’s happening,” or, “This is why you’re still here for four hours.” So when they go and they’re ignored, that just amplifies how they already feel about how they are generally treated. They don’t feel that they are wanted, or that they’re a desirable patient or that their needs are met.

As we continued talking, Logan shared his “work around” strategy for this problem:

When you come from my approach, you learn who those ones are [that don’t use this approach], and you try to steer the people that you care about away from them... I’ll call ahead and ask, “Who is working today?”

As Logan explained, if the nurse on duty at the local emergency department is one who he knows does not practice using a culturally safe approach, he will suggest that his client wait, if possible, until shift change or the next day; in this way he tries to protect his clients from culturally unsafe treatment. Other nurses in this study observed clients using their own “work around” strategies. Brenda, for example, observed Aboriginal clients at the rural community health centre where she was working trying to avoid seeing some of the nurses on staff:

There were definitely a couple of nurses that were always a little more harsh, and they kind of did what was medically necessary, but didn’t seem quite so warm, or

want to build relationships. And I observed that there was a reaction, and that people in the walk-in clinic tried to avoid seeing them.

For Aboriginal peoples who live in remote communities, options for culturally safe care can be even more limited, as Patty explained:

I'm glad that the communities do have a nurse but some of the nurses in the nursing stations are awfully bossy and territorial. So I feel bad for the people, they might have a question that they won't ask.... There are a couple of ways they get around it: depending on who the nurse is, the clients might not come in; they'll wait the month until somebody else is in there.

As discussed earlier, not only do Aboriginal peoples experience discrimination when they access health care services, they are also more likely to experience an increased burden of poverty and poor health, including mental illness, addiction and chronic disease such as diabetes. As outlined in my literature review, research has documented that health care providers can attach negative and discriminatory labels to all of these diagnoses; this labeling behavior is especially likely when the provider does not problematize the idea that these health issues are the result of individual failings. Furthermore, although waiting in an emergency department or being labeled are not experiences that are exclusive to Aboriginal peoples, being made to feel that they are undeserving patients based on their identity is; as discussed in chapter two, a potent constellation of colonial assumptions about Aboriginal peoples as abusing the system and receiving unearned benefits can and do influence health care professionals' treatment of Aboriginal peoples in observable ways. A quote from Kelly's interview reveals how this kind of labeling practice can look:

The Native population, they just don't seem to take care of themselves. Diabetes is huge in the Native population, huge. They all come in with uncontrolled diabetes, poor diet, foot sores, need amputations, the whole nine yards! And I

don't know how you would change that, because it is like 2015, come on! You know the education is out there, but do they just choose not to? Why? I don't know.

In the above quote, Kelly recognizes that the Aboriginal population in her area bears an especially high burden of diabetes and diabetes-related complications. However, by saying that all Aboriginal people do not take care of themselves, the cause of diabetes is identified as the result of a deficit in the Aboriginal community, effectively severing the impact of colonialism on Aboriginal communities from their contemporary burden of disease. This is an example of the lifestyle discourse at work, a colonial discourse that, as discussed in my literature review, is popular in western health care, insists that all patients have the same choices, and in so doing ignores the historical and social context of peoples' lives.

Kelly's interview contained numerous well-circulated expressions of colonial discourses, and as such it was unlike the other interviews in my study. However, it was clear that the nurses were quite familiar with these expressions and sometimes caught themselves expressing similar frustrations. For example, they described scenarios where they witnessed discriminatory labeling and the reluctance of nursing colleagues to take care of Aboriginal patients, especially patients known to department staff as frequent users of services. That is, interviewees repeatedly indicated that the heavy burden of disease in Aboriginal communities led to Aboriginal patients being negatively labeled by health care professionals. Of particular concern for participants was the label frequent flyer when applied to Aboriginal patients. An excerpt from Kelly's interview illuminates the dimensions of this label well:

You get your frequent flyer come in, and it's like, "Oh God! Not again!" They just won't listen—you can go through all their teaching, you know, "Don't do this, you shouldn't be doing that." And then, four days later, they come back with the same thing. It's just, "Oh god! Not again!" I shouldn't say it like this but you get tired of it.

As this excerpt from Kelly's interview illustrates, the frequent flyer label is given to patients who are well known to hospital staff, based on repeated emergency visits and hospital admissions for chronic, ongoing health issues. As the last sentence of Kelly's quote suggests, nurses often become frustrated with these patients. In the present study, the concern about the frequent flyer label emerged in the interviews with both early career and experienced northern nurses, working in emergency departments or in-patient units, in both urban and rural communities and regardless of geographical location. In the following quote, Evelyn describes how the care of patients labeled as frequent flyers differed from the care provided to other patients in a rural northern hospital:

They would call them "frequent flyers" there. And I even saw it in some of the care that I witnessed...that the nurse was different with the patient, was shorter with them, less compassionate, less explaining of what was going on, took less time, or certainly made it clear in their attitude that they didn't have the time for the patient. There was a difference there: they were less friendly, and I didn't really see people try to make relationships with the patients.

When Evelyn's description of caring practices described above is compared with the relational construction of culturally safe care reported in the previous chapter, it becomes visible that the care of patients labeled as frequent users lacks the qualities of culturally safe care. When I asked Dawn if she'd noticed negative attitudes towards Aboriginal people at the rural hospital where she works, she replied, "Yeah, I would say so. Fortunately, it is with a small percentage, I think. But it's especially with alcohol-

related admissions, such as GI [gastro-intestinal] bleeds and withdrawals. It's often, 'Oh, it's so-and-so again.'”

In the next two vignettes, two early career nurses describe their experiences watching their nursing colleagues avoid Aboriginal patients labeled as frequent users of services. Anne for example, recounted a situation where paramedics brought an Aboriginal woman into the rural Ontario emergency department where she was working as a new grad. As she explained, her nursing colleagues left the patient waiting for hours on a stretcher. By way of explanation, one nurse told her, “Oh, you’ll see her, she’s in here all the time.” As Anne described further:

The nurses were saying to each other, “I don’t want to take her,” “She’s always in here,” “She’s just complaining,” “She’s not in pain,” “There’s nothing wrong with her.” Finally I signed up for her, and she said, “My stomach hurts, I can’t pee.” So I asked the doctor if I could do an in/out catheter, and he said, “Yeah, that’s fine.” So I got the order and I did it, and there was a massive output, and it was to the point where she really needed it. I don’t know how much longer she could have waited on that stretcher. Was it because she was Native? I don’t know.

Cathy, an early career nurse working in an urban emergency department in western Canada, described a similar experience:

A couple of nights ago, for example, someone who comes in frequently came in. She comes in every week, sometimes every day, and everyone just saw the name and was saying, “I don’t want to see this person.” Everyone left it for a little bit, trying to avoid seeing her. In the end I saw her because I thought it's not fair for this person to be waiting like this. I thought, “She might be sick, maybe this one time.”

In Anne’s story above, the nurses identified the Aboriginal woman waiting on the stretcher as a frequent user with their talk at the nursing station. Knowing that white patients who are frequent users are also judged negatively and treated poorly, Anne is

trying to understand if her colleagues didn't want to see this patient because she was Aboriginal. Anne is also trying to understand if this is an example of racism. This effort was not uncommon among the nurses in this study: Meg, for example, talking about the labeling practices she had observed among some of her colleagues explained, "It's not just against First Nations patients. It's about individuals with addictions, and the single moms with a low socioeconomic situation." Dawn shared a similar sentiment when we talked about the labeling practices surrounding frequent users on her unit: "It's not just for Aboriginal patients: I can think of quite a lot of patients who are frequent users and are Caucasian." I asked her if the care provided to Aboriginal patients with alcohol-related issues was any different from that provided to Caucasian patients. Dawn tried to explain:

But what's tricky I guess is, if the Aboriginal frequent user is in with a GI bleed or an alcohol-related issue, then that's when it really gets awful, I think, in terms of nursing care. But...it isn't awful, but that's when it kind of falls apart. It's when these stereotypical things that people are admitted for, that's kind of when it [nursing care] falls mostly to the wayside. It's interesting also, because the Aboriginal frequent user, in for alcohol withdrawal, is a lot more common, so it does kind of perpetuate that stereotype. I mean I can't even remember the last time I had a non-Aboriginal CIWA [Canadian Institute Withdrawal Assessment, a scoring tool used widely in Canada to score the severity of alcohol withdrawal symptoms], or GI bleed. So it's hard to make that exact comparison. For the frequent flyer that's a CIWA or GI bleed, that's when I really notice that the care is different, but then in saying that, the care is always different with frequent flyers, just in terms of attitude of the nurse going in the room. I hope that clears that up.

In the above narrative, we learn that in the area where Dawn works, the local Aboriginal population carries a significant and disproportionate burden of alcoholism. As a result, it is more likely that patients with alcohol-related issues will be Aboriginal. It is also likely that these patients will be labeled as frequent users, be subject to stereotyping, and

receive suboptimal care. As Dawn tries to pull apart the complex intersection of stereotypes about Aboriginal people as alcoholics, the stigma surrounding alcohol use, and the discriminatory frequent flyer label, we can see that she is also hesitant to identify racism at her work place in this situation, which, as discussed in chapter two, is a common problem among Canadian health care providers.

Some nurses in this study, however, identified the frequent user label as racism when it was applied to an Aboriginal patient. Jolene, for example, an experienced Aboriginal nurse working as a community health nurse in a small, northern community shared this reflection about the frequent flyer label:

As a community nurse I go to hospital meetings, and we talk about the patients in rounds—and I pick up on the racism, even in there. I can hear it in the talk, “Oh so-and-so is in again.” I wonder if that same person...you know they call them “frequent flyers,” if they were non-Native, would they still think the same thing? I’ve often wondered that.

Jolene’s reflection, like Logan’s at the beginning of this chapter, demonstrates the awareness that the frequent flyer label is an example of racism when it is attached to an Aboriginal patient. As Logan states, when Aboriginal people are judged as undesirable and undeserving patients in health care, this amplifies how they feel they are treated in Canadian society; used in this way, the frequent flyer label, although it is used with non-Aboriginal patients, becomes a colonial and racist one because it reflects colonial ideology.

When nurses allow labels to interfere with their work, and they avoid or ignore patients, as in Anne and Cathy’s stories above, the consequences can be dangerous for patients. As discussed earlier in chapter two, the death of Brian Sinclair after waiting for

34 hours in an emergency room is a potent exemplar of how racism can and does influence the practice of providers in contemporary health care environments in Canada. The story of Brian Sinclair, however, carries different lessons for different people, as I discovered in three of my interviews. Anne and I, for example, talked about how her experience in the rural emergency room shared parallels with what happened to Brian Sinclair:

Researcher: The story of Brian Sinclair is a powerful example of what we're talking about

Nurse: It's kind of similar to the lady I talked about who was waiting on the stretcher. I mean, if I hadn't have brought it to someone's attention, who knows how long she would have been waiting there.

In this exchange, Anne is struck by the realization that she has witnessed what nurses do to avoid patients, and how difficult it can be to overcome the situation—remember that Anne indicated in her story that some time passed before she *finally* signed up for the woman on the stretcher. For Patty, the story of Brian Sinclair is a reminder not to assume that someone else has checked on a patient:

You know about that man that died in the Winnipeg hospital, Brian Sinclair? I think we can at least educate new staff to not let that happen. Sometimes there'll be people waiting around in our waiting area and if I notice someone there, I will go over and say, "Are you okay? Does someone know you're here? Are you here for an appointment?"

Although Patty doesn't explicitly refer to racism in this excerpt, her interview revealed her to be someone who is trying to pay attention to the impact of racism, as her reference to micro-aggressions in chapter four indicated.

As discussed earlier, however, not everyone is willing to see the racism in Canadian health care. Similarly, not everyone sees the racism in the Brian Sinclair story;

Rachel, for example, made the compelling argument that his story is about understaffing and nurses' frustration with frequent users:

Researcher: I've said to my nursing students, "I don't want you to be a nurse that ends up on a stand because you let stereotypes prevent you from doing your job."

Nurse: I understand that but I do feel for the nurses, because I've worked in emerg and I do understand being so busy. I think it's a lack of funding. Here we don't have a casual pool for the RNs. For the first seven years of my career here I probably worked short more often than I did fully staffed.

Researcher: Wow.

Nurse: And I understand how some people can become very jaded and disillusioned. When you are run off your feet and you have to take care of someone that you just got fixed up and here they are again. I do understand the frustration of it.

Rachel's statement that she worked short-staffed more often than not for seven years is a powerful statement about the realities of nursing workload in contemporary health care environments. However, as discussed in chapter two, the story of Brian Sinclair is not just about nurses being busy and understandably frustrated; surveillance cameras showed that other patients and visitors begged nurses at the desk to help Brian. Rachel's argument, however, is not an uncommon one; as discussed in chapter two, just as health care providers are reluctant to identify racism in health care, the administration at the Winnipeg hospital similarly refused to accept that racism played a role in Brian Sinclair's death. As a researcher, there were moments during my interviews when my participants took up colonial discourses including the avoidance of racism, and this was one of those moments; I inwardly cheered when Rachel went on to identify the importance of reflection in professional and culturally safe care:

But as nurses and professionals we're supposed to be able to at least step back and say, "Let me reflect on why I'm feeling this way, and go talk to somebody." You know, "Am I really giving the best care I can if I'm frustrated that they're back?"

The Work of Resistance: Using Cultural Safety to Challenge Racism

At the beginning of this chapter, I suggested that health care professionals need to possess a critical social awareness in order to be able to challenge the pervasive notion that frequent use of the emergency department, chronic illness and addiction are all the result of individual failings. In the following narrative, Brenda describes how her consciousness of race and colonialism helps her to bring compassion to her interactions. By engaging in a critical social analysis, informed by cultural safety, Brenda works to resist stereotypes, racist thinking and the frustration that accompanies the label of frequent flyer. As Brenda explained:

The way I deal with that in my own practice, or when I think about those interactions when I might feel similar frustration or even just sadness that someone is back again and again, is by turning towards an analysis of colonialism and that this is a socially constructed phenomenon. It allows you to continue to provide care and not blame...an individual person, or their culture, i.e., “Because they’re Aboriginal, they do this.” If you recognize it’s a social construction then it allows you to pull back from that and look at the bigger picture. For example, “What are the living and social circumstances that are leading people to go down these roads that are so destructive to themselves and their families?” That helps me think, “Well, of course they’re back,” or, “Of course they need more care.” As opposed to blaming them for not getting their lives together.

This is one of the most important points I want to make in this chapter: that instead of labeling someone as a frequent flyer, an analysis informed by cultural safety can help the provider to acknowledge that an Aboriginal person, who occupies a stereotype, has actually been created, or constructed, by colonialism. This perspective, accompanied by reflection, can help providers to shift their thinking from, “Oh, you’re back again,” to “I’ve been expecting you.” Evelyn, for example shares how they respond to patients at the acute care unit where she is currently working:

There are people that we have frequent admissions for, but no one would ever use the term “frequent flyer.” Everyone pretty much has the understanding that people are back in because they have an exacerbation, and we fix them up over a week or so, then we send them back home with adjusted meds and following up with the physician. That’s what we do—we get them into a good spot again to go back home—it’s an understanding that at some point they likely will be coming back in.

By the above discussion, I am not trying to suggest that maintaining a culturally safe approach or enacting a critical social analysis is easy or straightforward. Given that colonial discourses are so pervasive and persistent, it is important to point out that cultural safety is challenging for nurses, and nurses in this study wanted to stress this point this as well. Brenda describes this challenge for the team of nurses she works with at a rural community health centre:

I guess the biggest thing that came around is stereotypes about behavior. For example, an Indigenous person who is drunk is a stereotype, right? A “drunk Indian.” So, when people did come in and were drunk and had been fighting or whatever, I feel like those were the moments that were the most challenging for all of us, to not bring those stereotypes or disgust that you had to look after someone who was “totally gone” and hurt themselves or someone else, or was dangerous because they weren’t in control.

Dawn shared this reflection about how the nurses she works with support each other:

I think most people kind of bitch and rant as a coping mechanism on our nursing team, but sometimes I think that as much as what they’re saying can be negative and bad, it’s kind of like they’re “checking it” at the nursing station so that they can go in there and do an okay job, if that makes any sense? And I feel really fortunate because we do function well as a team. There are a lot of people that will stand up and say something, but it would be more of a supportive thing, rather than a “Oh, don’t say that, you shouldn’t say that about people.” It would be more like, “What’s going on? What can I help you with?” So we are really good at supporting each other in those kinds of situations, when people are feeling particularly negative or perpetuating stereotypes.

Other early career nurses shared that although they were critical of their colleagues' practice at times, they were not always immune to feelings of frustration, as Anne describes:

Even me, I remember I had a patient come in about three times moaning and moaning in pain and I remember feeling frustrated after a certain point—at first I was super compassionate but by the third visit I was abrupt and said, “What is it?” I could see it rising in me and I’m a new nurse, you know.

It appears that Anne did not anticipate that her compassion as a nurse would know these limits, simply because she is a new nurse. As discussed chapter four, the nurses in this study linked compassion and caring with the provision of culturally safe nursing care, and often with their identities as nurses as well. As a result, feeling frustrated with patients is outside of this construction. As Cathy explains, she is unable to reconcile her feelings of frustration toward patients with the kind of nurse she expected herself to be:

I have started to feel like I am losing that excitement towards work. I've been getting more and more frustrated with seeing people who repeatedly come in and are abusing the system. I see that I'm getting to the point where I'm not as tolerant with these people anymore, and when I catch myself doing that, I think, “Okay, maybe I need to do something else.” I just don’t want to be one of those nurses who is jaded and burnt out.

As discussed in chapter two, racist talk often signals dominant in-group membership. In Cathy and Anne’s stories above, the senior nurses who label the patients as frequent users with their talk and reluctance to provide care are also inviting Cathy and Anne to join their in-group. As a result, the early career nurses are immediately faced with a conundrum: to join in with the team, on whom they depend for support and mentoring as new nurses, or to be accountable to themselves for the kind of care they want to provide, and the kind of nurse they want to be. As discussed in my literature

review, nurses are often drawn to the profession by the desire to make a difference and to help people, and the ability to draw emotional satisfaction and feel efficacious in this regard is one of the factors that determine whether or not they stay in the profession. With their talk at the desk, the senior nurses in Cathy and Anne's stories are also signaling that they are jaded and defeated; they are defeated because they believe that they cannot make a difference in this person's life. For Cathy, feeling frustrated is a signal that she is becoming jaded and burnt-out, and that it may be time to move on. Not knowing how to respond differently to so-called "difficult patients," Cathy said in her interview, "It's hard and frustrating with some of the populations that are difficult to work with. How do I work around that?"

It is well known from the literature, and as discussed in chapter two, that for all patients, including those who have been mistreated or labeled in the past, or who are dealing with ongoing chronic health issues including alcoholism and addiction, that being treated with respect and dignity is memorable and does make a difference for them in that moment. The challenge of cultural safety for nurses early in their career, then, is not only to resist the invitation to join colleagues in taking up discourses that justify the avoidance of patients, but to bring the empathy, respect and compassion of cultural safety to every encounter, every time; to know that they can and do make a difference, in peoples' lives, simply by entering into a respectful relationship with them. As Rachel said, "We should always treat someone as if it was the first time they were coming in." For nurses, a memorable interaction is also about making a meaningful connection with patients. Anne described such an experience that has stayed with her:

One day I had a young Aboriginal girl, I think she was 11 or 12; she was a kid and had been sexually assaulted by a family member. She had been suicidal and she had a long history of sexual abuse. For some reason I had extra time on my hands that day and I gave her a piece of paper and some markers and she just drew me the most beautiful picture. It had a really big impact on me. Just having that time—and I didn't have a lot of time—I sat down with her for maybe ten minutes, but it was that extra amount of time that was huge... It's really special when you do have those moments, and those are the moments that stick with you, and you think, "My job is really meaningful and I am making a difference in this person's life."

Here Anne is describing an important ten-minute interaction from her first year of practice. Although it is likely that this young person will return to hospital for support and treatment of her mental health issues in the future, Anne feels that in connecting with her, she has made a difference in this young person's life. For Anne, this interaction has contributed to a feeling of efficacy in her work as a nurse.

During this study, I asked all of my participants if they had witnessed any situations where an Aboriginal patient might not have been safe, and in response, as the discussion here has revealed, many of the nurses talked about situations where patients were labeled as frequent users. I also asked my participants if they were able to intervene in these situations, and why or why not. In response, nurses shared stories of when they were pressured by colleagues to withhold empathy and culturally safe care. In Cathy and Anne's stories of watching their colleagues avoid Aboriginal patients in the emergency room, they both shared that some time passed before they finally intervened on the patients' behalf. As Cathy stated, she finally decided to see the patient because she thought it wasn't fair to keep the patient waiting, and "She might be sick, maybe this one time." When Anne intervened, she discovered that her patient actually needed urgent nursing care. As many of the nurses in this study shared, another challenge they often

encounter is the persistent myth that providers contribute to the problem of frequent users by providing these patients with comfort care. Evelyn recounted this story from her time working in a small rural hospital:

I remember witnessing a conversation in the nursing station after a night shift. The supervisor was there, and a few of us nurses, and the nursing supervisor was talking... She'd been down in emerg and she was complaining about what was going on down there, and she made a comment that really stuck out to me. She said, "Oh, it's like they're coming to a hotel! They get a warm meal, they get a nice warm bed to stay in, they get someone to care for them, so of course, they're going to come back in." That was the supervisor. And I sat there and listened to that and was just completely flabbergasted.

Other nurses in this study shared similar stories. Anne, for example, described that the nurses she was working with one night wanted to discharge a young Aboriginal woman in the middle of the night. In this situation, the woman had come into town for an appointment, and after being found lying outside intoxicated, had been brought to their rural emergency department to sober up. As Anne recalled:

She was just this young, vulnerable woman...and they wanted to discharge her in the middle of the night, even though there was no one else in the emergency room. I did advocate for keeping her there overnight and helping her get to her appointment in the morning...but they said that the emergency isn't a hotel and there's nothing medically wrong with her. The attitude was, "Oh, she's just using the system."

Jolene described a similar experience from her early years as a nurse working in the local hospital:

We used to have this fellow that used to come in all the time; lots of times he'd be intoxicated, and we always had extra sandwiches at that time and people wouldn't offer them to him, because he's always in there, and he's an Aboriginal guy. And I just thought, "That's what the sandwiches are for!" And they would say, "Well he's just coming here 'cause you feed him!" and I'd be like, "No. He's not coming here because I feed him. He's got some mental health problems, he's an alcoholic." So I'd always offer him a sandwich, or at least crackers and water, and some people wouldn't.

Tammy has also encountered this phenomenon in the rural hospital where she works:

What I've heard people say, is "Don't encourage them." So if a person comes in and they say they're hungry and you give them a sandwich, they [the nurses] say, "Don't encourage them, that's just what they're going to come back for." So where's the cultural safety there?

In these stories, the nurses are describing the negative response of fellow nurses to their provision of comfort care to marginalized patients. In Jolene's story above, she was able to stand up to her peers; in her words, what helped her to do this was a firm belief in her own accountability: "Because really, it's you morally that has to go home with how you're treating patients and how your shift went, right?"

The above assemblage of quotes is meant to draw attention to how common it is for nurses to encounter the belief that comfort care encourages repeat visits. On close examination, it is visible that this perception is used to support ideas about what is an appropriate use of health care services and who is a desirable, or undesirable patient: the frequent user is clearly undesirable and not to be encouraged. As Jolene shared in her interview, when one of her community care clients is hospitalized, she is often criticized during rounds by hospital management: "We get questioned from home care, 'Oh, aren't you guys seeing them at home?' And yeah, we are!" In emergency departments, the desirable patient is one with a medical emergency. As Cathy stated in her interview: "We kind of try to set the law in emerg that we only deal with the physical aspect, we don't want to hear anything about the mental or social side." As Tammy describes, this is a very strong belief in the emergency department at her hospital:

So it's really strong, this culture of "We are specialized nurses, trained to deal with traumas, heart attacks, seizures, code blue," and that's all they want to see.

Well in any emerg, you're going to see the people who have very little health care, they don't have proper nutrition, they have substance abuse issues—it's not just here. And sometimes this is the only place people access health care.

As discussed earlier, there is a gap in primary care services across Canada that affects marginalized groups most profoundly. As a result, the emergency department is often the only option—and an important safety net—for many Aboriginal people to access primary care services. Tammy's comments here reflect the understanding that many of the patients in Canadian emergency departments do not present with health needs that are triaged as needing emergency medical attention. Despite this information and their ongoing experience regarding the patients they serve, emergency room nurses where both Tammy and Cathy work continue to regard patients that request attention for non-emergent health needs as undesirable. When this analysis is linked with the heavy burden of poor health borne by Aboriginal peoples, we can see how biomedical reasoning can be used to conceal that Aboriginal peoples are being judged as undesirable patients; knowing that this practice—using biomedical criteria to triage a patient as undesirable—will affect a disproportionate number of Aboriginal peoples and mirror social discrimination, it becomes visible that this practice does not reflect culturally safe care.

Tammy described it this way:

I think if nurses really wanted to take the time to know why someone has walked into that emerg department when they don't really look sick, I think that's where the cultural safety piece comes in—it's when nurses see each person as a valid human being, when they want to know, "Why are you here?"

Participants also shared that "schooling in racism" was common, especially for early career nurses. For example, when Anne provided her patient with a sandwich from the fridge and tried to advocate for the patient to be able to spend the night in the

emergency room, she described her colleagues' attitudes towards her actions this way: "It was kind of like, 'Oh, you're naïve, you don't understand what's actually going on here, you're too soft, you're too green,' stuff like that." Evelyn shared that she had encountered similar attitudes from senior nurses:

I know that some nurses take the perspective that, "Well, you don't have any experience." Which is very similar to "You don't know how it is." Or, "You have a city view." And whether people said it or didn't say it, you kind of knew that they were there to school you a little bit.

With this kind of pressure to not provide care, intervening on behalf of patients is challenging, especially for the early career nurse who is new to the team and trying to develop confidence. As Anne shared:

That environment put me in a weird position, where it's like if I do that then they're staring at me, as if to say, "What are you doing?" You know? So I mean, I did advocate for her, and maybe I should have been stronger, but there was a limit to how far I felt comfortable going.

The intention of the above discussion is to make visible the social dynamics that early career nurses navigate in contemporary health care environments and highlight the challenges they can face when trying to intervene on behalf of patients and provide culturally safe care. In the quote above from Anne, she was clearly motivated to advocate on behalf of this patient, but she was intimidated by the attitudes and comments of the nurses she was working with that night. Meg, an experienced northern nurse, has witnessed this kind of intimidation during her career. When I asked her if she had seen early career nurses voice dissent at work she stated, "Young nurses will rarely speak up because they feel intimidated. Because unfortunately, I've seen a lot of senior nurses, and unfortunately, there are some people who are bullies." Skylar, an early career nurse

currently working in a large urban hospital, also talked about how social position and hierarchies influenced early career nurses' abilities to speak up at work:

I don't think it's realistic, if you're a new nurse. I think there is a huge amount of social stuff going on, at least in the culture of nursing, or whatever unit or team you've become embedded in. There's a lot of hierarchy within the team. Nurses like their hierarchies, and the oldest nurses run the institution. That hierarchy matters. So you know, having a new nurse who has been there for less than five years, actually stand up and say something, I think they have to be fairly clever about how they do that.

Other early career nurses described themselves as lacking experience with this kind of advocacy. I asked Dawn, "When you hear your colleagues say things that aren't respectful, that are full of those stereotypes, do you feel uncomfortable?" Dawn, in her second year of nursing practice, responded this way:

Yeah, I do. And mostly because I'm not a very confrontational person, so I don't really say things, I just kind of sit there and have my own opinions, and keep them to myself. Maybe that'll change with a little more experience. But I don't know, it's not really in my personality and I kind of see that as a little bit of a flaw, because, I would like to be more of an advocate, I'm just not really there yet.

As Cathy shared, she also finds it difficult to speak up with colleagues, because she does not want to criticize them:

The way some people respond to frequent users or that kind of population that are manipulative or difficult—I see how some of them approach [the patients] in a very harsh way, to the point that it's not reasonable, but it's very hard to speak up because you don't want to undermine that colleague's ability. You don't want to make your colleague feel that she's incapable of dealing with that kind of patient situation. It's very confrontational and can get personal sometimes. A colleague can take it very personally.

Sam, an early career nurse currently working in an urban emergency department agreed with Cathy's perspective, that confronting a colleague wasn't effective. I asked him how he responds when he hears colleagues say something that isn't culturally safe:

Maybe I'll try to say something indirectly, maybe, "You've had a tough day?" You know something, non-confrontational. Kind of try to bring the balance back, instead of this brooding feeling of frustration. Just try to lighten up the mood. There's no point in trying to confront anybody, it's not effective at all. Just try to lighten the mood, because everybody's working in the same environment, including myself, right? So there's no point to be just frustrated all the time, because it's never going to change—emerg is still going to be hectic and busy, and you're still going to deal with different people with different issues, acute and non-acute.

Meg, an experienced northern nurse, acknowledges that it can be challenging for anyone to speak up with a colleague about any issue, and that it takes courage and practice:

If I do approach someone—and it's being brave and taking that challenge—I often rehearse things, I write it down, or on my drive home I talk out loud. I practice saying, "We had this experience, it made me feel this way, I wonder if we could discuss it?" [If you speak up] then you know that you've done everything that you possibly can.

In the following narrative, Ivy describes some of the complexities of speaking up with colleagues, which include being torn between being collegial and naming racism, between being supportive and raising consciousness:

It can be extremely frustrating at times, because there's comments that come out that are intended to be, "I see you as a friend and I'm venting and I'm complaining about a certain scenario," and you're trying to be supportive of that person's feelings as a coworker and their frustrations, but you don't agree with what they just said, at all; so it's difficult to find that balance between this person's already frustrated and I'm going to correct them and lecture them on something? I think, "What's my goal in this conversation? What does this person need? Does my coworker just need support? Or is this a good opportunity to maybe do some education? Because I really don't to agree with the statements that have just been made. But there's a reason why that person approached you. So trying to find that balance between when it's appropriate to contradict and put my own opinions out there, versus when to say, "I understand that you're frustrated," and try to ignore the fact that those comments were inappropriate...you don't want to poke a bear!

These narratives illuminate some of the important considerations involved when nurses contemplate entering into a potentially difficult conversation with a colleague,

especially one that involves identifying racism. The nurses' accounts suggest that they are reluctant to provoke conflict and are sensitive to the fact that a colleague can become defensive if she thinks she is being called a racist. As discussed above, difficult conversations with colleagues require forethought, practice, and courage, because work relationships are long-term relationships. These kinds of conversations also require an appropriate moment, as Ivy's narrative suggests. Finding an appropriate moment, however, can be very difficult, especially in busy hospital settings, as Cathy shared in her interview:

Researcher: When we think of it in our personal lives, if we have to have a difficult conversation with someone we care about, we wait for a quiet moment, when we've got some time and some room. But in the emergency department, it's pretty hard to get that kind of opportunity.

Nurse: Almost never!

Some nurses, however, had found ways to broach sensitive topics with their colleagues without being confrontational. Skylar, for example, shared that she has found that being curious and asking questions can be an effective and non-confrontational way to talk to nursing colleagues about their practice:

I think that's how I started to speak up in my practice, was to ask a lot of questions of people that I didn't necessarily agree with their approach. It reveals a splinter. It reveals an absence of thought, just a rote process that they've always been doing, but have no idea why they're doing it, or what it means or how people perceive it, because they've been doing it for so long.

Other early career nurses shared that they had also used this technique of clever questioning when they wanted to talk to colleagues about racism or discrimination toward Aboriginal patients. For some, it was a technique that they had practiced when they were students or buddied with a mentor as a new grad, and they needed a non-confrontational

way to approach a difficult discussion with a nurse with whom they were working closely for a period of weeks or months. When I asked Ivy if she had any success talking with her colleagues about racism, she shared her experience using this technique when she was new to the rural hospital where she now works:

Nurse: I think [name of colleague] might have been the most racist of all of my coworkers. She made a ton of comments that just made me entirely uncomfortable. She's very smart, so her comments were very well put together. I kind of took it as a learning goal to try to figure out where she got these ideas.

Researcher: How did you do that?

Nurse: We worked together in emerg a lot, and she was often saying how frustrating the Aboriginal patients were and how policies like free medical travel allowed them to abuse the system and all of that stuff. So I asked her questions like, "Why is that policy in place?" and "Do you think there are scenarios where that's a good thing?" trying to kind of dig into how she sees the entire scenario.

Researcher: So you approached it as a "learning conversation"?

Nurse: Yeah, like, "I'm new here, educate me," kind of thing. It was interesting, but frustrating at the same time, because I'm sitting there thinking, "I don't agree with this," and I could throw in my opinions in small amounts, but I really wanted to say, "What are you thinking?!" I wish I could have said more in those scenarios, but I don't know that it could have been done in a way that wouldn't have negatively affected me.

In some of the early career nurses' narratives, including Ivy's above, it is visible that although they may be uncomfortable with their colleagues' comments or practice with Aboriginal patients, they are also concerned with how speaking up might impact them. As Anne stated above, "There was a limit to how far I felt comfortable going." During the interviews in this study, and as the discussion above has indicated, it is evident that speaking up about racism and care practices is a considered a complicated and delicate undertaking for nurses. As Naomi explained so well:

I think it's a complex equation that people sort of add up in their head about whether or not they not they have the energy or safety to engage in conversations like that with their colleagues, or their patients.... They think about job security

and personal energy when they're considering intervening when they hear a racist thing, or a homophobic thing, or sexist thing.

Participants were also convinced that there are some colleagues whose negative views toward Aboriginal peoples are so deeply ingrained that talking to them about their views is unlikely to create change. For example, after sharing a story of challenging a fellow nurse's racist comment at work, Naomi admitted, "I don't think it made a huge earth shattering change in the person's attitude." Ivy, now that she has been working as a staff nurse at her hospital for over a year, she has given up on trying to "fix" the attitude of her colleague in the emergency department: "Now I just avoid those conversations with her because she's not the kind of person who would be interested in having a discussion about it and changing her opinion." After my interview with Kelly, I felt I could understand Ivy's desire to avoid having conversations with her colleague about Aboriginal issues; as much as I tried to insert an alternative viewpoint, Kelly continually segued into racist discourse:

Researcher: Some of the material coming out of the Truth and Reconciliation Commission makes the point that addictions are often about trying not to remember a traumatic past.

Nurse: Exactly, trying to forget. I guess that's the easiest way they know how to do it. I mean, there are other paths to take, you know, have some counseling. I'm sure lots of people have had traumatic problems and choose to move on. I know myself in my, my childhood—I chose to move on, I'm not going to dwell on stuff.

Researcher: Some people talked about how when traumatic experience affects your whole community then it compounds the effects and makes it harder to heal.

Nurse: Absolutely. So how do you fix the problem? Come in and integrate into society and get off the reserve. I mean there's nothing out there.

In the exchange above, Kelly has taken up some of the key colonial discourses discussed in chapter two; that Aboriginal peoples are inferior; that assimilation is the solution; that a connection to the land can be ignored as "nothing." It is not hard to imagine that trying

to disrupt Kelly's attitudes would be difficult, and perhaps impossible. The result was that after talking with her, I felt complicit in her racism. In my field notes after her interview I wrote: "I found myself anxious for my responses to her racist comments—would I agree with her? What would she say next? How would I respond? I felt complicit in her racism, like I was in secret collusion with her." Beyond feeling complicit, what are the possibilities when colleagues have stubborn racist views? Ivy has looked for and found opportunities for anti-racism with colleagues who are more open to considering ideas from a cultural safety perspective:

There are lots of people on staff that I have had conversations with and people have been very receptive to my opinions, even when my opinions have been different from theirs. I've had some good conversations. So I think you need to assess that person's beliefs and how deep-rooted they are and whether or not having a conversation is just going to spike an argument, or whether some good could actually come from opening up a new perspective and challenging the initial idea that had been put out there.

By having conversations with colleagues who are open to thinking about Aboriginal peoples and issues from a cultural safety perspective, Ivy is contributing to a change in the discourse on her unit. Naomi, however, argued that we cannot address racism in health care without addressing our colonial society:

It can feel like a drop in the ocean, when there is this colonial society, it's still going on, the pipelines are still being built, the fracking continues, the land appropriation happens, and women are missing—there's all that. The underlying society piece, and that's what is supporting the super-racist ideas that people are holding in themselves. So for me [speaking up is] not addressing the root cause of these views, but it's still important.

From the discussion and participants' quotes above, it is clear that nurses encounter a complex field when they consider challenging racism in their work environments. Staff hierarchies and their own feelings of safety are important

considerations, as well as their experience and comfort level with these kinds of conversations. Some of the early career nurses shared that they are concerned about being confrontational and prefer to use their colleagues' discriminatory comments as a cue that they need support. For the nurses who are trying to change the conversation at work, they have discovered that clever questioning can be an effective and non-confrontational strategy; some have also discovered that addressing racism with colleagues who hold deep-seated colonial beliefs requires conversations with other colleagues and broader strategies that reach beyond that particular nursing unit.

In this chapter I have talked about the derogatory frequent flyer label and how it intersects with racism toward Aboriginal peoples in health care. When I asked my participants if they had ever witnessed a situation where they thought an Aboriginal person might not have felt safe, their examples involved situations where Aboriginal patients had been labeled as frequent users and the justifications and rationalizations of health care professionals not wanting to provide care. Although being labeled as a frequent user is not exclusive to Aboriginal patients, it was these stories that the nurses in this study shared when they talked about examples of racism toward Aboriginal peoples in health care environments. Stereotypes about Aboriginal peoples as receiving unearned benefits, not taking care of themselves, as being alcoholics or abusing the system surface when this label is used and reflect more broadly how Aboriginal peoples are viewed and treated in Canadian society. This observation emerged from the data in this study

regardless of where the nurses work or had worked, suggesting that racism towards Aboriginal peoples is indeed systemic in contemporary health care environments in Canada.

In their stories, the participants shared that intervening on behalf of their Aboriginal patients and providing comfort care sometimes provoked strong opposition from their nursing colleagues. Study participants shared stories where they felt they were pressured to delay or withhold care and were judged negatively by their peers when they did not. Study participants also described feelings of discomfort and complicity when colleagues made disparaging comments about Aboriginal peoples, and at the end of this chapter I began to explore the nurses' experiences with speaking up and voicing dissent among their nursing colleagues. In chapter six, I will further explore participants' thoughts on advocating for cultural safety and addressing racism through speaking up, political action, leadership and nursing education.

CHAPTER 6

PERFORMING CULTURAL SAFETY

In the previous two chapters I have explored the concept of cultural safety and the participants' observations of racism in contemporary health care environments. In chapter four my discussion focused on how the nurses in my study construct cultural safety; how they understand the concept and how their work and relationships as nurses have informed this understanding. In general, my data revealed that for many of my participants, being a nurse has deepened their appreciation of how colonialism has impacted Aboriginal peoples. In chapter five I explored my participants' experiences of racism toward Aboriginal people at work, and their narratives often focused on the discriminatory label, the frequent flyer. My discussion examined how the frequent flyer label is a health care construction, one that symbolizes the harms of colonialism. For many of the nurses, using a cultural safety lens allowed them to observe how racism and colonial practices have created the poverty, addictions and unmet health needs that bring the person to seek health care services over and over again. The nurses also observed how health care providers use this construction to justify delaying and withholding care. In chapter five I also used examples from the data to show how a critical social analysis informed by cultural safety is helping some of the nurses in this study to resist taking up these discourses, and the struggles and challenges they face in trying to do so. In this chapter, I will further explore the nurses' thoughts on addressing racism through speaking up, political action, leadership and nursing education. I will demonstrate, using examples

from my data, how some of the nurses have become allies with Aboriginal peoples, and identify the dimensions of work environments and nursing education that can support or hinder this development.

Dimensions of Work Environments and their Influence on Culturally Safe Practice

To begin the discussion in this chapter, I will present a comparison of the work environments and attitudes of some of the early career nurses who participated in this study. Consistent with the method of Situational Analysis, I will use quotes from participants' interviews to compare and contrast their perspectives on the elements of their work environments that have influenced their nursing practice. I will begin by examining a quote from Cathy, an early career nurse who works in a busy urban emergency department in western Canada. In this quote, Cathy explains why it is challenging for nurses to work with patients who are frequent users:

It's frustrating, when you see that you have tried so hard and they come back and they weren't ready for that change.... You try to give them resources to try to help them get out of the situation that they're in and they're just not ready.... I've kind of learned that you can only do so much, and I even have said to patients, "Why is it that I feel like I am caring about you more than you are caring about yourself? This is your health and I'm just trying to help." I've had that kind of conversation with patients before and unfortunately sometimes they're just not ready.

As discussed in the previous chapter, nurses often enter the profession with a desire to make a difference. In the above narrative from Cathy, it is evident that the frustration that results when the motivation to make a difference collides with the belief that the health problems of frequent users are the result of their own individual failings. As discussed in my literature review, the ideology of individualism is at the heart of such

beliefs, and it obscures the social, economic and historical contexts of peoples' lives.

When the label of frequent flyer and the health care provider's frustration are examined using the lens of cultural safety, (specifically the impact of colonialism and trauma on Aboriginal peoples' lives), the provider's unrealistic expectation comes into view: that a provider can change patients' socioeconomic situation or experience living with trauma and addiction, simply by giving resources, such as a phone number or a pamphlet. As Skylar, an early career nurse working in an urban hospital in Ontario, stated in her interview, this is an overestimation of the power of health education that blames the patient:

I think it's fairly obvious, if you work in nursing, that the patients have very little control in how their lives actually play out. So we make judgments all the time around these behaviors that we think we can fix with 'patient education.'

As discussed earlier, although it is important to offer patients and clients support and resources, it is known from the literature that community resources are not adequate to meet the need. The gap in primary care services, the poverty on reserves, the harms and traumas of colonialism—these are institutional and system level issues that need to be addressed with advocacy and policy work at the institution and system levels. As a result, a nurse working in a hospital or clinic, whose position involves providing primary or direct care, cannot and does not address the gap in primary care services, the poverty on reserves or the trauma and harms of colonialism simply by coming to work. When viewed from this perspective, it becomes visible that it is this unrealistic expectation that creates frustration for nurses and other health care professionals, not the apparent inability of patients to change their circumstances.

It is important to note, however, that although the ideology of individualism is pervasive in health care, cultural safety education and a relational approach can disrupt stereotyping and the assumptions that accompany it. Sam, for example, worked for four months in a remote, fly-in community during the first year of his nursing career. In the next two quotes from his interview, he reveals how his knowledge of colonialism and interest in relationships has informed his perspective on his experience:

Usually when I share my experience with other people, their first question is, “What do you think? What do you think needs to be done to help them?” I tell almost everybody that the question itself is very hard to be answered. There's no one thing that would “help.” It's a web. It's very complex.... It's very hard [to explain to these people] when they don't have that education.... I think the mindset, “We're going in there to help them,” –that is a problem, and it's very common among nursing students and new nurses. They think, “We're going to go in and make some changes.” And then they realize that they're not going to change anything.... It's going to stay the same regardless of what you do.

When viewed in light of the preceding discussion, it can be seen that what Sam is saying reflects an understanding that the provision of primary and direct care services do not create lasting change. Sam also mentions the importance of education in understanding these issues. As Sam and I talked further, I became aware that Sam's ability to draw satisfaction from his nursing work in his current position at an urban emergency department is supported, in part, by his interest in building relationships with his Aboriginal patients—a point made in chapter four. As he shared during his interview:

It's definitely the relationship part that matters a lot. One of the reasons I picked [name of emergency department] is because I definitely see one or two Aboriginal people every day—and I'm glad for that because I still see that same population, and I still get to have those relationships.

These insights from Sam suggest that for him, a cultural safety approach, informed by education and a focus on relationships, help him to resist the kind of frustration that

Cathy is experiencing at work. Sam and Cathy, for example, are both early career nurses, and both are working in urban emergency departments. In the previous chapter, I reported how Cathy shared that she is often frustrated at work, has observed that her colleagues get frustrated with so-called frequent users and difficult patients, and that she is thinking that she may need to move on. Moving on, however, leaves the racism entrenched. In contrast, Sam is clearly enjoying his work and looks forward to seeing the patients with whom he has developed relationships—the same kind of patients that Cathy and her colleagues are frustrated with. In the next excerpt from Sam’s interview, he reveals how his colleagues contribute to his satisfaction at work:

Nurse: I think I'm pretty blessed with this environment. I'm working with a lot of nurses who have an interest in working with Aboriginal people. Half of them have worked on reserves. And a lot of them work with MSF. So it's a lot of interesting perspectives that they bring—it's a good mix. And a lot of them, doctors and nurses, are very passionate about the population, different types of populations. It's definitely a very supportive environment.

Researcher: Would you say that you have some culturally safe role models there?

Nurse: Definitely—many nurses have been up north, worked with MSF—so not just Aboriginal communities but internationally too. They have very respectful attitudes.

Researcher: They have respectful attitudes towards difference?

Nurse: Yeah. And a lot of them pursue masters of public health, masters of nursing. A lot of them are working toward something, always learning... There are a lot of good learning opportunities, different kinds of patients; the nurses are supportive, both culturally and also academically.

In the exchange above, Sam identifies qualities of his colleagues that he considers important in the creation of a supportive working environment; they have worked in a variety of settings in Canada and internationally, enjoy working with Aboriginal peoples, and are engaged in continuing education. This narrative also suggests that Sam believes these qualities have informed his colleagues’ respectful attitudes toward difference. In

this milieu, Sam has found an environment that supports him in providing culturally safe care. While this discussion does not include data on other factors that influence nurses' job satisfaction, such as workload or staffing levels, comparing Sam's and Cathy's different perspectives on their work is intended to illuminate the influence of colleagues on nurses' attitudes toward their patients.

As discussed in chapter two, the TRC Calls to Action include the provision of cultural safety education to all students in medicine and nursing, as well as increasing the number of Aboriginal peoples working as health care professionals. Several nurses in this study observed how these kinds of interventions were influencing a change in the culture of the nursing unit where they worked. Ivy, for example, shared how the recent hiring of an Aboriginal nurse and increasing numbers of younger nurses on staff were creating a shift in attitudes where she works:

Nurse: We had a mostly white or non-Aboriginal staff for forever, and we only recently hired our first ever Aboriginal nurse.

Researcher: Really? Since you've been there?

Nurse: Yes, and she is phenomenal. But I've heard a lot of comments from people saying, "Oh we can't speak frankly because this person's around," and "We can't say our true opinions because..."

Researcher: You've heard this during shifts when she's not there?

Nurse: Yes and that really bothers me, because if they acknowledge that the comment isn't appropriate to be said in front of her, why is the comment being said in front of a white person? They often just assume that since I'm white I agree with their opinion, but I don't...and I find those comments very frustrating. I just think if they reflected on those kinds of things, like why is it being said at all and in terms of their own opinions and beliefs? But some [older nurses] have lived in this area for 50 years and that's how they were born and raised and those opinions are well ingrained.

Researcher: And they are used to being able to talk about Aboriginal people in a certain way at work?

Nurse: Yes. But now we are getting a newer group of nurses, who don't agree and it's an area of friction. Because for a lot of our newer nurses, cultural safety was

an aspect of their education and it wasn't 40 years ago. So it's a different perspective.

As discussed in my literature review, Ivy's frustrations with her colleagues' assumptions are not unusual; in settings where overt racism toward Aboriginal peoples is commonplace, white people often assume that other white people share their racist views. At the hospital where Ivy works, the presence of a new Aboriginal nurse is clearly disrupting the long-standing tolerance of racism expressed by nurses on the unit. Ivy has also observed that nurses who have learned about cultural safety in nursing school are starting to introduce a different viewpoint. In contrast, at the rural hospital where Dawn works, there is a well-established Aboriginal Liaison program and several Aboriginal nurses. As cited in chapter four, Dawn has observed how Aboriginal nurses influence the social dynamics where she works:

We do have a handful of First Nations nurses. So I think that really disables people from being really overtly racist, 'cause you can't, because it's your team, right? And they're exceptional nurses and really great people. So I think that that's always the reality that [nursing colleagues] are seeing both sides of the spectrum and not just the negative stereotypes are perpetuated.

From Dawn and Ivy's narratives emerges a glimpse of the important ways that Aboriginal nurses can and do influence a shift toward cultural safety in contemporary health care environments. As Ivy has observed, nurses with awareness of cultural safety support this shift.

Near the beginning of my data collection, several early career nurses shared that they believed that strong leadership from nurse managers was missing on nursing units where cultural safety was not consistently practiced by their nursing colleagues. It was for this reason that I felt it important to interview experienced northern nurses—to

understand the role of nurse leadership in cultural safety. Skylar, for example, an early career nurse, had the impression that no one in a small rural hospital cared about cultural safety, given the nurses' negative attitudes toward Aboriginal peoples that she routinely encountered in the emergency room: "It was hard for me up there to sort of feel like nobody really cared. Everyone was really quite happy with the band aids we were putting on things." In the previous chapter, I cited Anne's disclosure of being intimidated by the nurses she was working with in a rural emergency department. Anne, like Skylar, felt that no one cared about cultural safety. Anne suggested that the source of the problem was a lack of leadership:

Researcher: What do you think leadership might have done to help?

Nurse: With leadership you could have in-services on everything from training actual nursing interventions to cultural safety, and checks and balances on behavior. There are very [few] checks and balances because the one manager is the manager for multiple departments and many nurses.... She just wasn't around.

Here Anne recommends that providing a broad range of educational opportunities to nursing staff, including cultural safety education, would help to create a more supportive environment for the nurses, and help to shift attitudes. In this dialogue it is also evident that Anne feels that a busy nurse manager, who is not visible on a nursing unit is likely unaware of the attitudes and behaviors of staff nurses, and is therefore unable to interrupt discriminatory behaviors. However, managers can also face opposition to cultural safety, as participants in this study revealed. Tammy, for example, a nurse manager in a rural hospital, shared that although she is a strong advocate of cultural safety education at her hospital, she has not been able to bring all of the staff nurses at her hospital alongside:

I'm not going to be able to convince everybody here what I believe. I'm not. It's going to take generations for people to really get that. I was kind of in the right

place at the right time in the right mind frame to read what I read and go, “Oh my god!” and allow it sink in and believe it. I can't get all my nurses to feel that. I've been told that. It's basically been pushed back in my face and people have said, “You don't have a clue. You're in administration now. You haven't worked as a real nurse in years.”

This comment from Tammy reveals that although cultural safety education has had a profound impact on her, she is very aware that it has not influenced a change in attitudes in all of the nurses at her hospital. It also shows that despite her advocacy and leadership position, she too has encountered strong opposition to cultural safety education from some staff nurses; Tammy is being “schooled” in racism, just as reported by the early career nurses cited in chapter five. In another example, Evelyn, an early career nurse, shares her impression that the management team at the northern hospital where she worked was unaware of the negative attitudes and behaviors she had observed of staff nurses:

Nurse: I feel if people saw or heard comments like that at the hospital I'm at now, people would talk, people would say something, and eventually that would get back to the manager.

Researcher: And the manager cares enough that she would follow up?

Nurse: Oh yeah, she would. There's really good management there [in my current workplace]. It was just a really different experience up north. I don't really know what all the pieces would be, but there was some kind of major disconnect between what was really happening and what management thought was happening.

Again, however, a nurse manager's power can be significantly more limited in a situation like this than what is visible to an early career nurse working in a staff nurse position. As one nurse manager explained to me, just hearing about an incident did not give her any teeth to address the problem of culturally unsafe practice:

Researcher: Do nurses ever complain about their colleagues?

Nurse: No, they will not. Perhaps in very extreme circumstances, but otherwise, no, they are solid. They might talk about it amongst each other, and that story will get passed along, and then there will be a nurse who's really close with the manager and they'll go and they'll say, "Oh by the way, this happened on the weekend." But we can't do anything with that! That's just gossip! You know? Unless the patient complains, or a witness who saw it stands up and says, "I don't want to work with a colleague who can treat people like this. I'm going to go and talk to a manager about it and say this is what I saw." A manager can't go and talk to a nurse and say, "Hey, I heard it through the grapevine..." because they'll just laugh at you.

As discussed in chapter two, the current thinking regarding trauma-informed practice emphasizes that trauma awareness needs to be part of an organization's culture and embraced by all levels of staff, from reception through to senior management. Since a trauma-informed approach is integral to cultural safety, and if patients are to have an experience of cultural safety in an organization, cultural safety also requires this kind of support on an organizational level to be effective. In short, cultural safety is not only the responsibility of individual nurses and nurse managers. In this study, some of the experienced northern nurses emphasized that they felt strongly that senior management had an important role in the promotion of cultural safety in an organization. Meg, for example, a nurse with more than 20 years of experience, has held leadership positions during her nursing career in northern Canada; in one position she was responsible for the promotion of cultural safety education for nurses in a rural hospital, and she was well aware at the time that not all of the nurses were responding positively to having to attend the workshops. When I asked her what she thought was needed to change recalcitrant attitudes, she did not talk about the attitudes of the staff nurses. Instead she talked about the attitudes of senior management:

I think it starts from the top down. I don't think [senior management] speak it—I think it's written in a mission-vision-values statement, how we treat everyone, etcetera, etcetera, etcetera—but it's not lived by any means. There's disrespect among staff, to each other. So if you can't even respect your co-worker, how can you respect someone that you're caring for? In my previous job in management I felt I was fighting the fight, the good fight, on my own...but when I would raise issues, I was told to be quiet, and to stop it.... You never hear the CEO or the Director of Nursing or VP speaking of these things. And there's no one on the Board that's First Nations.

In Meg's narrative above, we can see how ineffective she felt her efforts were, without the support of senior management. This quote from Meg's interview also provides another important point, that Aboriginal people should occupy leadership positions in health care organizations. As discussed in my literature review, Aboriginal leadership or consultation is essential in creating culturally safe health care environments.

On an organizational level, several nurses in this study pointed out that the corporate orientations that they received at particular hospitals or community agencies were also an important expression of an organization's culture, reflecting how they put cultural safety into practice. In the next quote, for example, Skylar reveals that she chose a particular urban hospital as a workplace because it had a reputation as a progressive institution with values that resonated with her own—and these values were emphasized during the orientation that she received when she first started working there:

Nurse: There's a lot of training that happens at [name of hospital] for nurses, training for almost every issue, and cultural safety was a huge part

Researcher: As part of their orientation for new staff?

Nurse: Absolutely. We had to go through all kinds of training—how to approach problems, what would you say, ways to negotiate your own biases—that was part of my orientation. It was for gender, race, everything. [Name of hospital] does do a good job of that, of training their staff

Researcher: I do visit there and I have seen their equity posters up on the wall, and posters about being allies—and that is the only institution where I have ever seen that in this city.

Nurse: Correct. They are a pretty progressive institution.

Researcher: This orientation that you did then, tell me about it.

Nurse: It was a full day process, where we were encountering patient stories, and we would have to get together in groups and formulate how to broach a certain problem, or where you would refer them, and to actually negotiate whatever was actually going on. So that was half the day. And then we went through the human rights charter—it was pretty solid. I was impressed. It was actually those policies and that type of stuff that kept me there...because that approach extended to staff...it was really important to me that everyone be aware that you just can't say certain things.

In this exchange Skylar identifies important elements of this hospital orientation, which included a review of the charter of human rights. As discussed in my literature review, the TRC Calls to Action include that students in nursing and medicine learn about the UN Declaration on the Rights of Indigenous Peoples. During her interview, Skylar shared emphasized how important this component of the orientation was:

It's part of our [nursing] training that we're really into the individual's rights. That we're supposed to stand up for patients and advocate or protect or help them understand...that idea of a basic human right, you can't ignore it.... It's the lowest level of what needs to happen.

Schooling in Critical Reflection: Multiple Pathways to Cultural Safety

In my exchange with Skylar cited above, Skylar is also saying that based on the orientation that she received at this hospital, she felt that she could expect to be working alongside colleagues who had thought about race and gender and were mindful of their own biases. As a woman of colour with Aboriginal ancestry, Skylar shared during her interview how her skin colour and life experience had informed her sensitivity to racism and privilege. Now, as a health care provider, Skylar has observed that discriminatory talk and oppression often goes unacknowledged in health care; in her opinion, one way to

address this problem is to provide nursing students with opportunities to reflect on their privilege:

You know, I think it is important to have nursing students, particularly in programs where they attract a high-income student, pushed to think about these things a little bit more, to think about their position and their privilege. Because the oppression that can happen in health care is insidious.

As discussed in chapter two, Aboriginal scholars and educators in higher education are advocating that students be encouraged to reflect on privilege and oppression during their post-secondary education, and Skylar's suggestion is reflective of this current thinking in higher education. While some of the early career nurses shared that they had been exposed to this kind of reflective exercise during their nursing programs, this was not the case for all, as Gordon indicated during his interview:

Researcher: Was being reflective about your practice something that they talked about in your nursing program?

Nurse: Not that I recall. I mean there was lots of reflection throughout the nursing program, in the courses. I think that's a learning method? Like the ways of learning?

Researcher: Yes, but there's also reflecting on your own attitudes and beliefs. In any of the courses were you ever encouraged to do a project or think about your take on how you feel about difference? Or working with difference?

Nurse: No, not that I recall.

This excerpt from Gordon's interview links with the discussion in my literature review regarding the quality and type of reflection in cultural safety; some scholars have pointed out that cultural safety requires critical self-reflection, one that engages the student in contemplation about colonialism in conjunction with their attitudes, beliefs and bias; reflecting on self without this dimension is unlikely to disrupt discrimination and stereotyping.

As mentioned earlier, the TRC Calls to Action also include that students in nursing and medicine receive content that addresses treaties, Aboriginal rights, the history and legacy of residential schools and anti-racism during their education programs. Gordon indicated that early on in his program, he received some of this content:

Nurse: We had a First Nations history class in my second year.

Researcher: What kind of things did you cover in that course?

Nurse: A little bit of the Residential Schools, and the Indian Act was in there, but a lot of my classmates complained about the class.

Researcher: Why? Was it a required course?

Nurse: Yes. But some of the material that was taught was quite irrelevant at the time. It would be better to have a First Nations component to continue all throughout the nursing program.

As other researchers have found, students in professional programs often have a vocational orientation to the courses in their programs; to be effective for students, content needs to be explicitly linked with professional practice. Similarly, Naomi shared that while her class received anti-racism content during a lecture, it was also not well-received by all of her student colleagues:

We had our anti-racism lecture squeezed into our mental health course, and I would be talking with students afterwards and they'd not have understood it at all!! They'd say, "You know, even though I'm white, I've struggled and I've worked hard to get here," and "I've experienced discrimination!" It was upsetting because I felt it was a testament to that whatever had just happened in the class had not been effective. I think it's so important to try but something was not effective there.

Just as Gordon's colleagues resisted content that they viewed as irrelevant to practice, the resistance to anti-racism content is visible in Naomi's classmates' expressions of colonial discourses that deny privilege and insist on meritocracy. As discussed previously, such resistance is not uncommon, and points to the importance of providing students with

opportunities for discussion and reflection on privilege and racism, not just the provision of lecture-based content.

While these excerpts from Gordon and Naomi's interview point to how important content must be strengthened to be effective, as I have noted above, other early career nurses shared that they did have important learning opportunities during their nursing education that had sensitized them to cultural safety. Ivy, for example, described how her participation in a small discussion group with other nursing students encouraged her to reflect on the impact of colonialism on Aboriginal peoples:

Researcher: In [name of nursing course], we talked about colonialism and the residential school system. Had you ever learned much about it before then?

Nurse: No. And I felt that of that group, I was probably the person that had the least knowledge, which I found very interesting, because they [student colleagues] had background knowledge and I was going home and looking up some of the details of the things that we were talking about. I just didn't know enough to have really formulated my own opinions.

Researcher: You were learning about it for the first time?

Nurse: Yes. And I was also hearing some awesome opinions about it, that had been very well thought-out from a lot of knowledge and education, and I just had had nothing! So it was very eye opening for me to be able to learn about these things, and also [to be exposed to] peoples' opinions that had a lot more background knowledge.

Following this exchange, I asked if what she had learned in this course had been helpful at all in her work with Aboriginal peoples as a nurse. To answer, Ivy went on to describe her interactions with the nurse in the emergency department with whom she tried to talk about the importance of free medical travel for Aboriginal peoples, cited in the previous chapter. In doing so, she demonstrated that participating in small group discussion about Aboriginal issues not only exposed her to ideas and new knowledge, but also provided her with the opportunity to learn how to talk about these issues with others.

In addition to formal training, nurses in this study talked about university experiences outside of nursing school that sensitized them to privilege and oppression. For example, both Naomi and Sam had transformative learning experiences during their careers as undergraduate students. Naomi volunteered at a Women's Centre on her university campus, and during her interview she talked about the powerful impact that an anti-oppression workshop had on her perspective:

It was mandatory for all the volunteers who wanted to volunteer at the Centre. So here I was, this naïve, young white girl, who wanted to get in touch with feminism and stuff. Which was great, but then I did this anti-oppression workshop and it was kind of like, "Whoa! Racism exists and I'm White!" That was a totally painful and difficult experience. I thought, "Oh shit! My life is full of these unearned privileges! And the world is not fair!" It was two days long and we did scenarios and activities, and then we'd role-play and practice how to talk about difficult things.... So, doing those anti-oppression workshops gave me a different understanding of what it is to be an ally or in solidarity with a group of people. The understanding that I took from the anti-oppression workshop was that my role as a white person is to sit down, shut-up, listen, learn, have some humility, and stop taking up space, basically! That's what I learned that you do to be a good ally—you listen.

In this vignette, Naomi shares how this anti-oppression workshop helped her to overcome the resistance and self-defensiveness she observed in her colleagues following their anti-racism lecture. Similarly, although not a part of his nursing education, Sam shared that a university course in Aboriginal Studies had a profound impact on him:

Nurse: It definitely touched me the most because it was lecture-based, and oral. We'd talk about all this stuff in class, for example, the residential schools, traditional family values. Then when we'd go discuss it in the small group tutorials, and there were a lot of emotions for a lot of my classmates, because there were a lot who were Aboriginal themselves.

Researcher: Did you know much about Aboriginal issues before you took that class?

Nurse: No—that course was definitely an eye-opener. Especially when we talked about current problems like suicide on the reserves. I remember thinking, "Oh my god, what's happening?"

In the above exchange from Sam's interview, it emerges that exploring class content in small group discussion was an important feature of his experience in this Aboriginal Studies course. It is also evident that listening to his Aboriginal classmates in tutorial, and bearing witness to their emotion, are what made this course a transformative educational experience for him. In light of this, it is evident that this Aboriginal Studies course did for Sam what attending the anti-oppression workshop did for Naomi: it taught them both to listen, and it taught them both how to be an ally.

As discussed earlier, the literature identifies that working as an ally with Aboriginal peoples includes respectful listening, the importance of understanding oneself, and reflection on bias, privilege and oppression. This body of literature also stresses that getting comfortable with discomfort is an important part of the process. As Naomi stated above, what she learned during the anti-oppression workshop "was a totally painful and difficult experience."

As the quotes from Ivy, Naomi and Sam's interviews suggest, many of the early career nurses formally learned about colonialism and racism for the first time during their postsecondary education. For the older, experienced northern nurses, they were often exposed to this content through educational opportunities at work. For all of the nurses in this study, what they learned during their public education about Canada's history with Aboriginal peoples was deceptive and limited. In a quote cited in chapter four from Evelyn's interview, for example, she shared that what she had learned in public school about Aboriginal peoples and the settler population in Canada was very "neat and tidy." This bears repeating:

Nurse: In retrospect I don't feel that I got a good picture of what had gone on, in terms of atrocities that happened and things like that. There certainly was an understanding that Aboriginal Canadians were here first, and the settlers and military came after, but the history wasn't accurate to what I learned later on in the nursing program....

Researcher: So what you learned in [public] school about Aboriginal peoples and the settlement of Canada was kind of sanitized?

Nurse: Yeah. I remember reading social studies and history in school; it was "nice." Everyone just kind of lived nice. I don't remember too much, but I remember it just sounding a lot nicer than what I learned later on.

Researcher: The way you're talking about it and the way you are using your hands is making me think that maybe there was a question mark there?

Nurse: There was a gap.... There was kind of a murky background that was interwoven into our education system growing up. We learned a bit about things, but it was very "neat and tidy."

This description of public education emerged again and again from the interviews in my study. It's clearly important, as discussed in the literature review, that students and providers in health care receive cultural safety education, to address this gap of knowledge created and perpetuated by public education. However, my data has shown that while cultural safety education provided in postsecondary education and in health care organizations is helping to create a shift in some departments and nursing units, the discriminatory attitudes of some health care professionals are deeply ingrained and intractable. As Tammy shared, her experience of the resistance toward cultural safety education at her hospital has led her to believe that it is essential that this education needs to begin much, much earlier:

Nurse: Some of our nurses were raised in a time when certain comments were appropriate and certain ways of thinking were appropriate and not challenged. Until Canadians as a whole have a completely different perception of Aboriginal people, I think that it's important that we're giving this education to them. But I've been taught that it's not really making a difference in the mainstream. It might induce some conversations when they go home, which is great.

Researcher: Did you just say that you know that your training here is not making a big difference in the patients' experience in your hospital?

Nurse: Not yet. It's still too raw for a lot of [hospital staff] to soak up and believe.

Researcher: Just to believe it?

Nurse: [Nodding.] I still feel really strongly that we need to have these education sessions. And there are movements all over Canada, to start to have these conversations, right? So when kids are educated in elementary school about residential school and the '60s scoop' and the horrible living conditions and the horrible health care that people have had, and intergenerational trauma—until that is part of the regular public school curriculum and those kids have all grown up, and all understand this to be true.

Researcher: And when they begin to populate the positions in our hospitals?

Nurse: Yes. Until then I think it's still important that we do this. To say we tried. And I think if there's anyone who is on the cusp of wanting to buy in to this whole, "Man! Did we screw up" idea, then they'll kind of jump in and they'll go home and have conversations with their parents and their spouses and that's what we need to do for people our age. But it's the school age kids. Canada needs to change.

Each time I read this excerpt from Tammy's interview, I am struck again by my surprise at her revelation that some of the nurses at her hospital simply do not believe in cultural safety, given the high quality cultural safety education that they provide at this site; the sessions are facilitated by a variety of experienced instructors, including Elders and Traditional Teachers, and they are comprised of a variety of interactive activities, stories and opportunities for discussion. During her interview, Tammy shared how the organization had adapted the education over time in response to participant feedback, and how it had become part of the organization's orientation for new staff. She has also observed how the education they provide at her hospital has inspired some staff to go home and talk about what they have learned, while others have remained unmoved. This experience has shown Tammy that while it is important to provide this education and bring more people into the conversation about reconciliation, deep change will only come when all school-aged children are provided with education for reconciliation. As

discussed in chapter two, this is recommended by anti-racist scholars and is also one of the TRC Calls to Action on education.

In a parallel conversation, Naomi echoes Tammy's assertion that broad, social level change is needed to support change in the health care arena. In this excerpt from Naomi's interview, she shares her opinion about cultural safety and social change:

I think the piece about cultural safety that sometimes people miss, or all of us miss, because it's the really difficult piece, is how are we going to address those political, economic questions related to colonization in our society. That's the really difficult piece. And it's not really part of our jobs—the health system is paying me to give the medication, and to pump people in and out of the hospital.

If we view these two passages from Tammy and Naomi's interviews in light of earlier discussions regarding the ideologies of colonialism and individualism, and the pervasive and widely circulated discourses that accompany them, it becomes visible that both Tammy and Naomi are calling for a shift in social ideology, an excavation of epistemic racism in our society. As discussed in chapter five, racism at the systems and epistemic levels is enacted in interpersonal relationships, and as a result, in order to address racism in health care relationships, interventions are needed at the systems level in health care as well at the epistemic level of our nation.

As discussed earlier in this chapter, the nurses in this study shared many stories where their work as a nurse or an experience in higher education have been transformative moments of consciousness-raising; and these experiences of bearing witness can be important sources of inspiration for nurses in their development as an ally with Aboriginal peoples. Naomi, for example shared that bearing witness as a nurse has been her motivation to be involved on a political level:

I think the reason why we need to be politicized as nurses is because we are constantly bearing witness to the suffering of people from colonization and from capitalism.... We bear witness to the ways that colonization and capitalism get written on peoples' bodies in the form of illness and trauma and addictions.... And I think that the power for change that nurses possess comes from making the connections between the lived experience of people, the ways that illness is embodied by them, and making the connection with what's wrong in our society.

During her interview, Brenda also shared how bearing witness had influenced her desire to participate in the climate justice movement. For Brenda, seeing the high rates of cancer and respiratory illnesses in a rural Aboriginal community in northern Canada was a source of inspiration to become politically active outside of her work as a nurse:

Aboriginal leaders are really leading this fight against things like the expanded tar sands, pipelines, the use of Aboriginal land as dumping ground... Seeing the health consequences of these things, like cancer and respiratory disease, has been a big inspiration for me for working on climate justice. Even though I'm not working directly with Aboriginal communities right now as a nurse, by being involved in climate justice work I'm trying to do solidarity work with their health.

Tammy, Brenda and Naomi all shared that contributing to larger social movements have been important sources of inspiration for them. For Naomi, participating in grassroots political events is part of how she looks after herself as a nurse and an ally:

We were having this conversation the other day about self-care, and how we witness all these devastating things in nursing, and it can be hard to want to go on. And you know, self-care is taking a bath, eating properly and going to the gym. But instead of getting down about the realities of the world, I think self-care is also going out and trying to do something, or being part of something that gives you hope that things are going to change. Because otherwise, I think that the alternative is despair.

Brenda also described how participating in a large political rally had a positive effect on her:

Indigenous leaders were at the front of that march, leading it, speaking, and [there were] people from Aboriginal communities all over Canada, people who are on the front lines, who are calling for even more. It was so inspiring! That people are

still willing to come and talk to us about what they're going through and struggling through. It gives me hope because it means that they believe that we can actually do something to help. And basically, I'm glad that Indigenous folks haven't given up on the rest of us yet.

In this chapter I have discussed how a critical social analysis informed by cultural safety has been an important source of consciousness raising for nurses in this study. Bearing witness to the suffering created by colonialism also informs the nurses' motivation to work as allies in reconciliation. My participants' stories have detailed how the two main elements of cultural safety, learning about colonialism and critical self-reflection, help them to resist and disrupt pervasive colonial discourses in the health care arena. Working alongside colleagues who have an understanding of cultural safety and an interest in lifelong learning is also part of what makes a working environment supportive of culturally safe practice, and also helps nurses resist the trap of feeling frustrated with so-called frequent users or difficult patients. The nurses' stories have also outlined what makes cultural safety education effective in higher education and health care institutions, and this includes the provision of opportunities for discussion, interaction and critical-self reflection on privilege and oppression. While the majority of the nurses in this study have focused their attention on the health care arena, for a small number of nurses, a cultural safety lens informs their advocacy and participation in broader movements for social

change, including education and climate justice. Involvement in political action can be a source of inspiration for nurses, who bear witness to the suffering created by colonialism.

CHAPTER 7

CONTRIBUTIONS AND REFLECTIONS

In this chapter I begin by reviewing and connecting my research findings with the literature I reviewed in Chapter 2. I also reflect on my thesis journey and conclude with a consideration of directions for future research. I will begin with a summary of the major findings of my research study in the context of the scholarly literature.

Major Findings and Contributions to the Literature

As discussed in chapter three, I chose Adele Clarke's method of Situational Analysis (SA) as the method and methodology for my study for several reasons, including its ability to handle discourses and communicate findings to the nursing community. I also chose SA because it was a method that resonated with the way I process information on a conceptual level. While the first ordered and messy situational maps that I created in the planning stage of my research study were consistent with those published by Clarke, as I progressed through my data collection and analysis, I became creative with the method in order to facilitate my conceptualization and interrogation of the data. To do this, I began incorporating a wide variety of graphics into my messy maps, including shapes, pictures, words and arrows. As a result, the maps that I created are different than Clarke's maps, and demonstrate the flexibility of SA that had not yet been documented. My innovations with SA I believe, helped me to uncover numerous insights regarding nurses' experiences with cultural safety.

In chapter four, I presented my findings on my participants' construction of cultural safety, arguing that the nurses' narratives illuminate a relational practice, one in which cultural safety is understood and experienced in the context of respectful relationships with Aboriginal peoples. While the cultural safety literature advises nurses and nursing students to develop strong relational and communication skills and to build relationships with Aboriginal peoples in health care (ANAC, 2009a; Brascoupé & Waters, 2009; Van Herk et al., 2012), the literature does not, to my knowledge, explore the learning that happens when nurses enter into respectful relationships with their Aboriginal patients. For example, it is emphasized in the literature that learning about colonialism helps health care professionals to develop empathy (Shah & Reeves, 2015) and in chapter four I used examples from my data to illustrate that the nurses' respectful relationships not only helped them to develop empathy, but deepened it, and provided a profound awakening to the impacts of colonialism. In short, an examination of the construction of cultural safety in my data revealed it to be a relational concept, one that is not just experienced in relationships, but one that is also enhanced through relational learning in practice. This centering of relationships is also consistent with Indigenous knowledge paradigms and research methods, in which learning is relational and holistic (Wilson, 2008). The relational learning I have documented also demonstrates how nursing practice can extend the experiential learning of cultural safety in nursing education, and how profound and significant this learning can be. An important dimension of the relational learning uncovered in my study also includes the positive impact that working with Aboriginal nurses and Aboriginal Liaisons can have on non-

Aboriginal nurses. Furthermore, for some of the nurses in my study, bearing witness to the suffering created by colonialism also informs their motivation to work as allies in political arenas, revealing the link between the development of empathy and political action. These nurses also shared how involvement in political action can be a source of inspiration and a strategy for self-care.

In practice, some of the early career nurses described how their relationships with Aboriginal people not only deepened their understanding of colonialism in Canada, but also of the trauma created by colonial government policies, especially the residential school system. These nurses described how their insights working with residential school survivors taught them the trauma-informed approach that has been promoted in the literature. While the relevance of using a trauma-informed approach with Aboriginal peoples is already established in the literature (Haskell & Randall, 2009; Menzies, 2012), my findings add to the experience of McCall & Lauridsen-Hoegh, (2014), who argue for the explicit linking of cultural safety with trauma-informed practice when working with Aboriginal people in health care.

As stated in my literature review, a question for me in this study was how early career nurses navigate the tension between the time required for building relationships and cultural safety, and the time constraints of their hospital jobs. Managing heavy workloads and not having enough time to spend with patients has been identified as a key source of stress for early career nurses working in hospitals (Hodges et al., 2008; Honan Pellico et al., 2009; McCalla-Graham & De Gagne, 2014; Peterson, 2009), and cost containment and efficiency issues have become a persistent feature of modern health care

(Boychuk Duchscher & Myrick, 2008; Limoges, 2007; Peterson, 2009). The early career nurses in this study also talked about the time required to build relationships, and that heavy workloads interfered with cultural safety. However, even though many reported that they were often extremely busy, it was clear from their narratives that working in hectic environments was not forcing them to abandon the value that they place on interaction and relationships with patients; when they had a moment, many of the nurses in this study chose to spend it with their patients, to get to know them and their priorities; the nurses also indicated that building relationships and getting to know patients made meeting patients' needs and the nursing care they provided better and easier, and gave them moments of satisfaction with their work. That these nurses have found that a collaborative approach with patients is effective is consistent with the literature regarding trauma-informed practice and self-management support (BCCEWH, 2013; CCSA, 2014; RNAO, 2010). For nurse educators, this finding, coupled with the relational learning described above, opens up what cultural safety education can bring to nursing education in the context of contemporary efficiency-driven health care.

Key to the concept of cultural safety is a critical social analysis underpinned by postcolonial theory, and the cultural safety literature in nursing states that this understanding supports nurses in resisting the plethora of colonial assumptions and stereotypes about Aboriginal peoples (Anderson et al., 2003; Browne & Fiske, 2001; Browne & Varcoe, 2006). The nurses in this study experienced this benefit of using a cultural safety lens, and described how entering into respectful relationships with their Aboriginal patients and clients was a hedge against making assumptions, because in their

relationships they learned about the lived experience of Aboriginal peoples, knowledge that has been silenced in our public education systems. This finding adds a relational dimension to the intellectual understanding described in the literature.

Another important dimension of cultural safety that is emphasized in the literature is that it draws attention to unequal power relations in health care interactions, because the final determination of cultural safety care is meant to be made by the patient or client (ANAC, 2009a; Anderson et al., 2003; Browne et al., 2009; Rowan et al, 2013). The nurses in my study, however, shared what they had learned regarding how to level power differences, including establishing eye level communication, sitting on patients' beds and trying to find out what brought the person to seek medical attention. These practical suggestions are important additions to the nursing literature that might be generalized to other professional work.

In chapter five I documented my participants' stories of racism toward Aboriginal people in health care. When I asked the nurses if they had ever witnessed a situation where they thought an Aboriginal person might not have felt safe, the stories they shared consistently involved situations where an Aboriginal patient had been labeled as a frequent user of nursing services or "frequent flyer." Although such labels are not exclusive to Aboriginal patients, as has been clearly documented in the literature (Pauly et al., 2015; Clarke et al., 2014; Browne et al., 2011), it was stories about Aboriginal patients labeled in this way that the nurses in my study shared when they talked about racism at their workplace. This finding adds to recent studies that reveal how labeling practices in health care intersect with racism toward Aboriginal people and can interfere

with cultural safety in negative and dangerous ways (Allan & Smylie, 2015; Browne et al., 2011; Hole et al., 2015). While not all of my participants identified the frequent flyer discourse as racism, others did, and I argue that it is the widespread denial of racism that prevents nurses from seeing the racism in such labels.

A particularly interesting finding is how the discourse of individualism intersects with the frequent flyer label, and can lead health care professionals to become frustrated with their patients for their apparent inability to overcome situations that are in fact caused by colonial policies and practices. While the negative influence of individualism on health care practice has been documented in the literature (Beagan, 2000; Pauly et al., 2015; Tang & Browne, 2008; Travers, 1995), my research adds to the literature which suggests that a cultural safety lens and a focus on relationships with patients can also help nurses to resist the frustration towards patients that occurs when the discourse of individualism is not problematized. My participants' narratives also revealed that working alongside colleagues who have an understanding of cultural safety and an interest in lifelong learning is part of what makes a working environment supportive of culturally safe practice for early career nurses. In the context of the cultural safety literature, this is a significant finding that suggests that using a cultural safety lens can be an important dimension of collegial support and enjoying nursing work. This finding supports the suggestion from NAHO (2009) that using a culturally safe approach can contribute to health care providers' job satisfaction. Just imagine if more providers knew that resisting dominant discourses could actually contribute to professional satisfaction!

In their stories, the participants also shared that intervening on behalf of vulnerable Aboriginal patients and providing comfort care sometimes provoked strong opposition from their nursing colleagues. Study participants shared many stories where they felt they were pressured to withhold care or were judged negatively when they went ahead and provided care. The nurses shared that this pressure was often applied in conjunction with the myth that providing so-called “comfort care” encourages repeat visits; while this myth is not new in health care, it has not been widely acknowledged in the literature, and the way it is used to obscure a powerful racist culture that is present in some health care settings in Canada deserves more attention.

These findings reveal the complex social dynamics that early career nurses must learn to resist and navigate just to provide care to labeled and racialized patients, and the challenges they can experience when they attempt to confront racist practices at work. This is a bind for the early career nurse, who often looks to the more senior members of the health care team for guidance during their school-to-work transition. The patient safety literature has identified that nurses’ decisions to speak up are influenced by their experience and comfort level with difficult conversations, as well as power relations and staff hierarchies (Attree, 2007; Law & Chan, 2015; Sayre et al., 2012). My analysis concludes that early career nurses weigh these same factors when they consider speaking up and challenging racism at work. However, how the early career nurse actually goes about challenging racism at work is a significant contribution of this study. For example, some of my participants shared that they are concerned about being confrontational and prefer to use their colleagues’ discriminatory comments as a cue that their colleagues

need support; some have discovered that clever questioning can be an effective and non-confrontational strategy; and others have discovered that many conversations with receptive colleagues are required to shift long-standing tolerance of racist colonial talk.

The nurses' stories in my study also outlined what makes cultural safety education effective in higher education, and this includes the provision of opportunities for discussion, respectful listening, interaction and critical-self reflection on privilege and oppression. These are dimensions of experiential education and critical pedagogy, and my research shows how linking cultural safety education with these areas of higher education can open students to important consciousness-raising experiences in their practice as nurses as well as their commitment to social justice.

Future Directions

Addressing racism in the curriculum. I have argued that the dominant approach to thinking about and interacting with Aboriginal peoples in Canadian society and institutions is a deeply problematic and Eurocentric gaze that masks colonialism and racism. The concept of cultural safety, in leading nurses and nursing students to learn about colonialism and engage in critical self-reflection, acts as a mirror, to focus on one's own culture and attitudes and learn about the colonial past. Similarly, as Paulette Regan (2010) argues, this is also the challenge of the Truth and Reconciliation Commission (TRC) for non-Aboriginal people in Canada, to reckon with the history of residential schools, its profound and devastating impacts on Aboriginal children, families and communities, and begin unpacking what Regan calls the "benevolent peacemaker" myth

of Canadian identity (p. 11). Chaired by Justice Murray Sinclair, the TRC spent six years listening to and documenting the stories of over 6000 residential school survivors across Canada, concluding that the schools were founded on a government policy of cultural genocide (TRC, 2015). I have argued that the teaching and learning of cultural safety is one path in which non-Aboriginal nursing students can become allies with Aboriginal peoples and this argument has important intersections with the Calls to Action related to health and education identified in the TRC final report—such as Call to Action #24:

We call upon medical and nursing schools in Canada to require all students to take a course dealing with Aboriginal health issues, including the history and legacy of residential schools, the United Nations Declaration on the Rights of Indigenous Peoples, Treaties and Aboriginal rights, and Indigenous teachings and practices. This will require skills-based training in intercultural competency, conflict resolution, human rights, and anti-racism (p. 3)

These recommendations resonate with ANAC's (2009a) recommendations for cultural safety in nursing education described above, and demonstrate how the concept of cultural safety closely aligns with reconciliation. As I have outlined previously, cultural safety serves to address the gap in knowledge created by public education systems' silence on colonialism and its impact on Aboriginal peoples.

While it is essential that nurses and nursing students engage in this learning to repair and build relationships with Aboriginal peoples in health care, true change will only come when all people in Canada learn about Canada's colonial history, and this learning needs to start with children in public education. The mandate of the TRC was to inform all Canadians about what happened in residential schools and begin healing the relationship between Aboriginal and non-Aboriginal people in Canada (TRC, 2015). As Justice Sinclair says in a short video, *What is Reconciliation*,

It is the educational system that has contributed to this problem in this country, and it is the educational system...that's going to help us to get away from this.... We need to look at the way we educate our children...ourselves.... Reconciliation will be about ensuring that everything that we do today is aimed at...restoring that balance to that relationship” (TRC, 2012).

The affirmation of the importance of education in truth and reconciliation and in healing relationships, is also reflected in Call to Action #62:

We call upon the federal, provincial, and territorial governments, in collaboration with Survivors, Aboriginal peoples, and educators to make age-appropriate curriculum on residential schools, Treaties and Aboriginal peoples’ historical and contemporary contributions to Canada a mandatory education requirement for Kindergarten to Grade 12 students (p. 7)

Increasing the numbers of Aboriginal nurses. As discussed at the beginning of my literature review, increasing the Aboriginal nursing workforce was one of the original goals of cultural safety education in Aotearoa New Zealand (O’Connor, 2012; Papps & Ramsden, 1996), and this is also one of the goals of cultural safety in Canada identified by ANAC (2009a,b). This objective, however, is not new in Canada. Diane Longboat, for example, argued in her 1993 position paper for the Royal Commission on Aboriginal Peoples (RCAP), that providing Aboriginal communities with nurses of Aboriginal ancestry was essential in order to provide these communities with culturally safe and appropriate care. In 1996, RCAP recommended in its final report that universities and colleges work with Aboriginal associations to find ways to increase the enrollment and support of Aboriginal students in their programs, so that more would graduate. However, although some schools and communities have made efforts to increase and retain Aboriginal students in nursing programs, these efforts have not been enough to significantly address the shortfall (Smith, McAlister, Gold and Sullivan-Benz, 2011). In

1993 for example, Aboriginal health professionals made up less than one percent health professionals in Canada (Stephens, Degen, Hoy, & Matusik, 1993), and this number has not changed (Hunter, Logan, Barton & Goulet, 2004; Smith et al., 2011). Colonization, including the negative impact of residential schools on education in Aboriginal communities has been identified as largely responsible for this shortfall (Smith et al., 2011; TRC, 2015). The TRC (2015) Call to Action #23 is another shout out to governments “to increase the number of Aboriginal professionals working in the health care field” (p. 3). The ANAC (2009a) framework for integrating cultural safety into nursing education remains an important text to guide this work, as it recognizes that just as cultural safety is needed for Aboriginal peoples in health care, a culturally safe learning environment is needed in higher education and in nursing education specifically, to increase the number of Aboriginal nurses in the profession (p.2).

Racism in nursing. The focus of my study was on the racism toward Aboriginal patients and clients in health care, and as a result, my data does not speak to the particular challenges that Aboriginal nurses experience in navigating racism in the workplace. Just two of the 20 nurses interviewed in this study, Jolene and Skylar, possessed Aboriginal ancestry, and it was only Skylar who referred obliquely to her own experience with racism at work, by indicating her desire to practice in a setting where her colleagues knew “that you just can't say certain things.” Two of the white nurses in the study, Ivy and Dawn, both talked about how their Aboriginal colleagues disrupted racist discourse where they worked, as well as the positive impact that their Aboriginal colleagues had on them. I am aware that Aboriginal nurses may have a different view, as well as other

insights regarding being racialized in the health care arena. Racism in the nursing profession has been well documented, and contemporary studies have demonstrated that racism toward nursing students and nurses of colour persists (Johnstone & Kanitsaki, 2010; Modibo, 2004; Paterson et al., 2004; Vukic, Jesty, Mathews & Etowa, 2012). Vukic and colleagues (2012) interviewed 20 Aboriginal nurses working in eastern Canada, and found that Aboriginal nurses experience covert and overt racism at work, feel burdened with the work of addressing racism and feel that their skills, qualifications and contributions are often undervalued by their non-Aboriginal colleagues. My research adds to the findings of this study with the perspectives of early career nurses on racism in a variety of settings across Canada. This is clearly an area that deserves continued attention, especially to monitor the impact of schools of nursing as they take up the challenge of addressing the TRC (2015) Calls to Action described above.

Personal research plans. Moving forward I would like to explore further how critical pedagogy and cultural safety in higher education and nursing education can contribute to reconciliation. The TRC has recommended that all nursing students take a course dealing with Aboriginal health issues, but Shah and Reeves (2015) note that finding space for cultural safety education in cramped curricula remains an issue for many professional health science programs. The TRC however, compels programs to find creative ways of building and integrating this content into nursing education. On the strength of Sam's positive learning experience in an Aboriginal Studies elective, I would like to collect more data on the influence of Aboriginal Studies courses on nursing students and early career nurses. How would a prerequisite in Aboriginal Studies

influence the perspectives of students entering into nursing programs? Could such a recommendation influence the cultural safety of the learning environment experienced by Aboriginal nursing students in that program? Other important dimensions of such an inquiry would include examining students' experiences with required versus elective courses, and classroom versus online learning experiences. More data is needed to be able to make strong recommendations regarding the educational options that can not only fill the gap left by public education, but inspire nursing students, and ultimately nurses, to become allies with Aboriginal peoples in health care, and provide culturally safe learning environments that promote the recruitment and retention of Aboriginal students in nursing.

Reflections

As nurses in the early years of the new millennium, my colleagues and I recognized that what we did, what we were good at, was a relational practice, and that we had learned this from the Aboriginal people we had worked with. For myself and my white colleagues, we acknowledged the privilege and the gift of being invited into peoples' home and lives, given the colonial history and present-day racism that framed the relationship between Aboriginal peoples and the settler community in Canada. During my Master's studies, I wrote a theoretical paper arguing for cultural safety and relational practice as an appropriate framework to guide nursing practice in Aboriginal communities. That was almost 10 years ago, and the beginning of my academic interest in cultural safety. For me it is significant that the findings of my study support a

relational conception of cultural safety, and highlight the relational learning that emerges when nurses build respectful relationships with Aboriginal peoples. While my conception of relational practice is more informed than it was 10 years ago, in this way I feel I have come full circle over the course of my graduate studies in higher education.

My ideas about relational practice and cultural safety formed the jumping off point for my work as a nurse educator. Now as I end my thesis journey I would say that critical pedagogy and cultural safety are now the foundation of my teaching. One of my academic colleagues once said to me that higher education is more than what happens in the classroom; what happens after class, including the thinking, the reflection and the conversations, are important dimensions of higher education as well. Talking to the early career nurses in this study has shown me what early career nurses are capable of when they carry the experience of critical pedagogy and cultural safety into their nursing practice. Over the course of this study I have been astounded by what these young nurses are doing in practice to address power imbalances and challenge racism at work.

Summary and Conclusion

It has been well documented that Aboriginal people encounter racism in the Canadian health care system, and that a powerful constellation of colonial discourses is visible in nurses' differential treatment of their Aboriginal patients. As a nurse educator, a question that I hoped to answer during my study was, "How can I help to prepare my students to productively challenge racism in their work environments?" Hoping to build on the opportunity that students often choose nursing because they want to make a

difference, I regard the undergraduate nursing students that I teach as potential allies in the struggle to decolonize the health care system and make it a safe environment for Aboriginal peoples. During the course of my research, my data revealed over and over again my participants' commitment to providing culturally safe care, despite a myriad of challenges in a complex environment.

To conduct this study I interviewed 20 nurses to explore their experiences with cultural safety in their nursing work with Aboriginal peoples. During the course of their interviews, my participants shared how they construct cultural safety in their practice, and they also shared stories of the racism they have encountered toward Aboriginal peoples in health care. While previous research findings suggested that students in the helping professions don't know how to deal productively with racism once they reach the practice environment, my analysis revealed that the two main elements of cultural safety, learning about colonialism and critical self-reflection, can help early career nurses to resist and disrupt the pervasive colonial discourses in the health care arena. This finding suggests that cultural safety is an important tool for nursing students to carry into their careers, and supports the move to integrate cultural safety education into nursing curricula. However, my findings also suggest that cultural safety education is most effective when it is provided using experiential learning and critical pedagogical methods. This link between cultural safety and the higher education literature has important implications for nursing educators, suggesting that *how* cultural safety education is provided is an essential consideration. This finding is an important contribution to the cultural safety literature,

one that links nursing educators with a large body of knowledge to guide their teaching practice.

My data also revealed that the derogatory frequent flyer label intersects in powerful ways with overt racism toward Aboriginal peoples in health care. When asked if they had ever witnessed a situation where they thought an Aboriginal person might not have felt safe, the participants in this study consistently described situations in which Aboriginal patients had been labeled as frequent users, as well as the justifications used by colleagues to delay or deny care. In their stories, the participants shared that in such scenarios they felt pressured to withhold care and were judged negatively by their colleagues when they did not. This finding not only illustrates how colonial relations are recreated in present-day health care, it also provides a window into the challenging social dynamics that nurses must navigate in order to resist racism and provide culturally safe care, a perspective not previously reported in the literature. This finding is also a caveat for nurses that labeling practices and discourses signal racism when applied to Aboriginal patients and clients.

When asked to talk about cultural safety, the nurses in this study consistently described an approach in which they centred respectful relationships with Aboriginal people in their nursing practice. The nurses' stories also revealed the profound and often transformative learning that can happen when nurses enter into these respectful relationships. Given that the harms of colonialism happened in the relationship between Aboriginal and non-Aboriginal people (ANAC, 2009a), and that reconciliation is about healing the relationships between the two communities (TRC, 2015), this study has

revealed that nurses engaged in this relational practice of cultural safety have become allies in the work of reconciliation.

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Appendix A1:
Recruitment Poster

INVITATION:
NURSES WHO WOULD LIKE TO TALK ABOUT CULTURAL SAFETY

You are invited to volunteer in a University of Toronto study called: Caring About Racism: Early Career Nurses' Experiences with Aboriginal Cultural Safety. The study is voluntary. If you choose to be a participant in the study, you will be asked to share your thoughts in an individual interview, scheduled at your convenience. A summary of the research results will be available by request. This study is being conducted by a graduate student at the Ontario Institute for Studies in Education at the University of Toronto, in order to complete the requirements of a Doctor of Philosophy degree in Higher Education. The purpose of the study is to explore the experiences of recent University of Toronto nursing grads using Aboriginal Cultural Safety in nursing practice. If you graduated from U of T's Bachelor of Science in Nursing Program in 2012, 2013 or 2014 and have opinions about cultural safety that you would like to share, please consider participating in this study.

All those interested in participating or wanting more information please contact:

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Appendix A2: Recruitment Letter for Nurses

Dear [Participant],

Thank you for your response regarding the research study, “Early Career Nurses’ Experiences with Aboriginal Cultural Safety.” The purpose of the study is to understand the conditions that are supportive of culturally safe practice in nursing and how nurse educators can improve this aspect of nursing education. Completing this study is a requirement for my Doctor of Philosophy degree in Higher Education at the University of Toronto.

This study will require a 60 – 90 minute interview with you regarding your experiences working with Aboriginal peoples as a health care provider and using Aboriginal cultural safety. The interviews will take place in your home or in another private location, according to your preference. The interviews will be tape-recorded and your identity and affiliations will remain confidential. The information obtained will be used to further our knowledge regarding the usefulness of cultural safety in nursing practice and the implications for nurse educators.

Benefits for you would include the knowledge that you may have provided nurse educators with important information in relation to cultural safety education. Also, the interview will provide you with the opportunity to reflect on your own attitudes, beliefs and skill regarding the provision of culturally safe care to Aboriginal peoples and areas in which you feel more education is required. There are minimal risks involved in this study. For example, you will not be required to share any information that you are not comfortable in sharing. You can withdraw from the study at any time, or have the tape recorder turned off for particular questions. The names of all participants will be removed from the data and replaced by pseudonyms. Identifiers will be separated from the interview data and stored in a different file that is password protected. All electronic data will be stored on an encrypted file. Audio recordings of interviews will be saved for one year following the interview and then destroyed. Transcripts and field notes will be stored in a locked cabinet behind a locked door at the University of Toronto and will be saved for a period of five years following completion of the study and then destroyed. Participants will not be identified in study-related publications except by pseudonyms.

I would like to call you by phone to arrange a meeting with you to discuss this study further and your possible participation. If you have any concerns or questions, please contact me, Pamela Walker, the Principal Investigator, using the email address below.

Thank you for your time and consideration,

Sincerely,

Pamela Walker, Principal Investigator
PhD Student, Higher Education,
pam.walker@mail.utoronto.ca

Linda Muzzin, PhD
Thesis Supervisor for Pamela Walker
Department of Leadership, Higher and Adult
Education, OISE at the University of Toronto
252 Bloor Street West, Toronto,
l.muzzin@utoronto.ca

Appendix B1: Letter of Information for Nurses

Study Title:

Caring About Racism: Early Career Nurses' Experiences with Aboriginal Cultural Safety

Dear [Participant]:

I am writing to request your participation in a research study about cultural safety and nursing in Ontario. As a PhD student at the University of Toronto, I am conducting a qualitative research study to investigate the experiences of early career nurses using cultural safety in health care practice environments in Canada.

What is the study's purpose?

Aboriginal peoples often experience discrimination and racism in the health care system. The intent of cultural safety education is to increase awareness of local colonial histories and help health care providers identify the attitudes toward difference that they bring to their work. The goal is to change attitudes and produce a well-educated, self-aware and respectful workforce so that health care provided to Aboriginal people will be free of discrimination. In recent years, more health science students have received cultural safety education during their programs. The purpose of this study is to explore the effectiveness of the cultural safety education provided to students and how contemporary health care environments impact the ability of health staff to provide culturally safe care to Aboriginal patients/clients. I am planning to interview approximately 15 – 20 early-career nurses and five other health care providers, and am conducting this study to fulfill the thesis requirement for my PhD degree.

What is being requested of you?

As the principal investigator, I am requesting your formal consent to be interviewed at a time and location of convenience to you. Interviews will last approximately 60 – 90 minutes. I will ask you questions regarding the cultural safety education you received during your nursing education at U of T and your experiences with cultural safety at work as an early career nurse. With your agreement, I will record our interview and transcribe it for analysis in my study.

Is the interview confidential?

Yes. Your name will not be associated with any of the study findings, and the identities of interviewees will be strictly protected throughout the research project. Interview recordings will be transcribed immediately after our interview. A pseudonym will be used on the transcripts to identify each person interviewed, and the names of participants, the location and name of the work place will be removed from the transcript. The key associating individuals' names with interview transcripts will be stored in a separate and encrypted file that will be destroyed after one year. Throughout the study, all interview transcripts will be kept on a password-protected computer, in a locked filing cabinet and office. Only my thesis supervisor and I will be permitted to view the transcripts.

No information will be printed or released that would disclose any personal identities. It is possible that the stories shared by some participants will be identifiable on the basis of contextual factors, despite the removal of names and locational and organizational identifiers. As a result it may be difficult to attain complete anonymity when it comes to reporting of study findings. However, I will make every effort to protect your identity, and you may, up to six weeks after your interview, request in writing or by phone to have your interview transcript or a portion of it

destroyed. If I would like to include an anonymous quote from your transcript in a study-related publication, I will contact you and ask for your consent to include, withdraw or modify the quote in question.

What happens to interview transcripts after the study is over?

After this doctoral research study is completed, anonymous interview transcripts will be stored on a password-protected computer, in a locked filing cabinet and office for a period of one year or until publication of results, whichever comes first, and then destroyed.

Will the study be available to read?

You may request that I send you a copy of a summary of the final study report when my research is complete.

What are the risks and benefits of participating in this study?

There is minimal risk associated with participating in this study. Your participation is voluntary, and you may withdraw your interview or a portion of its content within six weeks of our interview. Your name will not be associated with the study findings. A benefit associated with this study is that participants will have the opportunity to have their perspectives represented in a scholarly research publication, contribute to research that will inform nursing education at the University of Toronto.

What are the rights of interview participants?

If you have any other questions about your rights as an interview participant please contact Dean Sharpe, Research Ethics Manager, Ethics Review Office, University of Toronto, by email at dean.sharpe@utoronto.ca or by telephone at (416) 978 – 5585.

Please keep this information letter and a copy of the informed consent for your records.

Your perspectives on cultural safety and the realities of trying to provide culturally safe care for Aboriginal people are important to this study. If you agree to take part in this study, I will review the consent process with you and provide you with a consent form.

Sincerely,

Pamela Walker, Principal Investigator
PhD Student, Higher Education,
pam.walker@mail.utoronto.ca

Linda Muzzin, PhD
Thesis Supervisor for Pamela Walker
Department of Leadership, Higher and Adult
Education, OISE at the University of Toronto
252 Bloor Street West, Toronto,
l.muzzin@utoronto.ca

Appendix B2: Letter of Information for Others

Study Title:

Caring About Racism: Early Career Nurses' Experiences with Aboriginal Cultural Safety

Dear [Participant]:

I am writing to request your participation in a research study about cultural safety and nursing in Ontario. As a PhD student at the University of Toronto, I am conducting a qualitative research study to investigate the experiences of early career nurses using cultural safety in health care practice environments in Canada.

What is the study's purpose?

Aboriginal peoples often experience discrimination and racism in the health care system. The intent of cultural safety education is to increase awareness of local colonial histories and help health care providers identify the attitudes toward difference that they bring to their work. The goal is to change attitudes and produce a well-educated, self-aware and respectful workforce so that health care provided to Aboriginal people will be free of discrimination. In recent years, more health science students have received cultural safety education during their programs. The purpose of this study is to explore the effectiveness of the cultural safety education provided to students and how contemporary health care environments impact the ability of health staff to provide culturally safe care to Aboriginal patients/clients. I am conducting this study to fulfill the thesis requirement for my PhD degree, and am planning to interview approximately 15 – 20 early-career nurses and five other health care providers.

What is being requested of you?

As the principal investigator, I am requesting your formal consent to be interviewed at a time and location of convenience to you. Interviews will last approximately 60 – 90 minutes. I will ask you questions regarding your knowledge of cultural safety and your observations regarding the cultural safety provided for Aboriginal patients/clients in your workplace. I am also interested in hearing your perceptions regarding the practice of early career nurses with cultural safety. With your agreement, I will record our interview and transcribe it for analysis in my study.

Is the interview confidential?

Yes. Your name will not be associated with any of the study findings, and the identities of interviewees will be strictly protected throughout the research project. Interview recordings will be transcribed immediately after our interview. A pseudonym will be used on the transcripts to identify each person interviewed, and the names of participants, the location and name of the work place will be removed from the transcript. The key associating individuals' names with interview transcripts will be stored in a separate and encrypted file that will be destroyed after one year. Throughout the study, all interview transcripts will be kept on a password-protected computer, in a locked filing cabinet and office. Only my thesis supervisor and I will be permitted to view the transcripts. No information will be printed or released that would disclose any personal identities. It is possible that the stories shared by some participants will be identifiable on the basis of contextual factors, despite the removal of names and locational and organizational identifiers. As a result it may be difficult to attain complete anonymity when it comes to reporting of study findings. However, I will make every effort to protect your identity, and you may, up to six weeks after your interview, request in writing or by phone to have your interview transcript or a portion of it destroyed. If I would like to include an anonymous quote from your transcript in a

study-related publication, I will contact you and ask for your consent to include, withdraw or modify the quote in question.

What happens to interview transcripts after the study is over?

After this doctoral research study is completed, anonymous interview transcripts will be stored on a password-protected computer, in a locked filing cabinet and office for a period of one year or until publication of results, whichever comes first, and then destroyed.

Will the study be available to read?

You may request that I send you a copy of a summary of the final study report when my research is complete.

What are the risks and benefits of participating in this study?

There is minimal risk associated with participating in this study. Your participation is voluntary, and you may withdraw your interview or a portion of its content within six weeks of our interview. Your name will not be associated with the study findings. A benefit associated with this study is that participants will have the opportunity to have their perspectives represented in a scholarly research publication, contribute to research that will inform nursing education at the University of Toronto.

What are the rights of interview participants?

If you have any other questions about your rights as an interview participant please contact Dean Sharpe, Research Ethics Manager, Ethics Review Office, University of Toronto, by email at dean.sharpe@utoronto.ca or by telephone at (416) 978 – 5585.

Please keep this information letter and a copy of the informed consent for your records.

Your perspectives on cultural safety and the realities of trying to provide culturally safe care for Aboriginal people are important to this study. If you agree to take part in this study, I will review the consent process with you and provide you with a consent form.

Sincerely,

Pamela Walker, Principal Investigator
PhD Student, Higher Education,
pam.walker@utoronto.ca

Linda Muzzin, PhD
Thesis Supervisor for Pamela Walker
Department of Leadership, Higher and Adult
Education, OISE at the University of Toronto
252 Bloor Street West, Toronto,
l.muzzin@utoronto.ca

Appendix C: Consent Form for Study Participants

Study Title:

Caring About Racism: Early Career Nurses Experiences using Aboriginal Cultural Safety

I acknowledge that I have read the letter of information accompanying this form, have had the study described to me, and have had an opportunity to have my questions about the study and my involvement in it answered. I agree to participate in the described study.

I understand that the Principal Investigator, Pamela Walker, (a PhD student at OISE at the University of Toronto), will be interviewing me, and that this study is intended to fulfill the thesis requirement for her doctoral degree. I understand that my interview is estimated to be approximately 60 – 90 minutes in length, and that it will be audio recorded with my consent.

I understand that the information I provide for this study during my interview will be kept confidential. The audio recording of my interview will be transcribed immediately after my interview and I will be identified on the transcript by a pseudonym only. The audio recording of my interview will be saved for one year following the interview and then destroyed. The interview transcript will be stored on an encrypted file in a password-protected computer for a period of one year following the completion of the study or until publication of results, whichever comes first, and then destroyed. The audio recording and transcript of my interview will only be accessible to the Principal Investigator and her thesis supervisor, Linda Muzzin.

I understand that the Principal Investigator will make every effort to protect my confidentiality. I understand that if any anonymous quotes from my interview are chosen for use in study-related publications, I will be informed and asked for consent.

I understand that my participation in this study is completely voluntary, and that I have the following rights: to not be interviewed; to stop the interview at any time; to request that the interview not be audio recorded or have the recording device turned off at any time during the interview; to not have the audio recording of my interview transcribed; to withdraw the transcript (or a portion thereof) from the study up to six weeks after the interview; to not allow any quotations from my transcript be used in study-related publications, all without any negative consequences. I acknowledge that perspectives from my interview may still be incorporated into analysis in the study, even if my transcript is destroyed at my request.

Date: _____

I agree to the interview being tape-recorded: _____

Signature of Participant: _____

I would like a summary of results sent to: _____

Name of Participant (please print): _____

Thank you for your participation in this study.

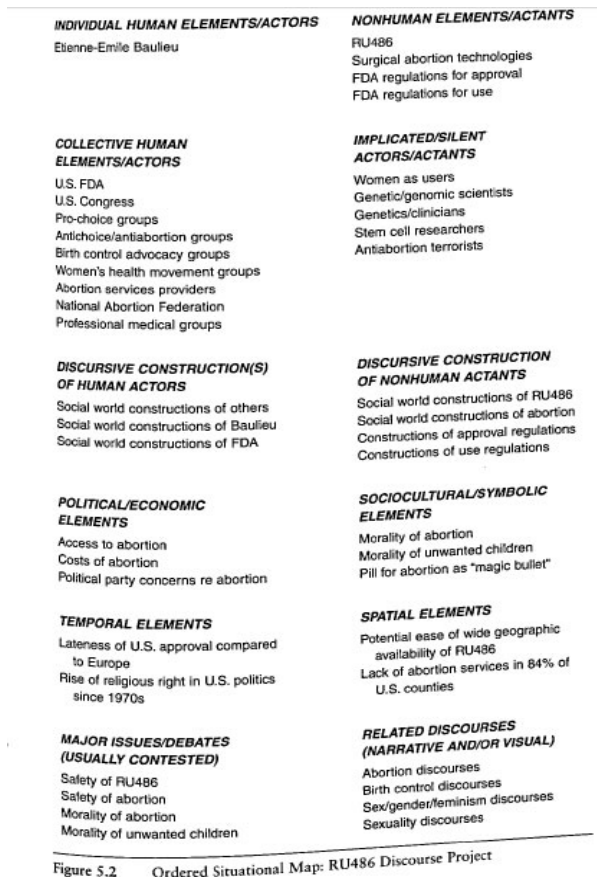
Appendix D1: Draft Interview Questions for Nurses

1. Name
2. What year did you graduate from Bloomberg Nursing's undergraduate nursing program?
3. What is your current position?
4. How long have you been in this position? Can you tell me a little about your position?
5. What other nursing positions (if any) have you held since you finished your nursing program?
6. Did you receive cultural safety education during your undergraduate nursing program?
7. Can you tell me about the cultural safety education you received during your nursing program? Was it a single session? Who provided it? How long was the session? Was it interactive? Were you provided with opportunities for discussion or reflection during or after the seminar? Was the information helpful to you? How have you used it in your practice? How would you define cultural safety?
8. Prior to being a nurse, what involvement, if any, did you have with Aboriginal peoples?
What source did your information about Aboriginal people come from (News media, community, school, family)?
9. Have you had any educational opportunities in regards to working with Aboriginal peoples? If yes, what motivated you to attend? Can you tell me what you learned and what was helpful?
10. If no, what barriers prevented you from attending? What would need to happen for you to be able to attend these types of educational opportunities?
11. Can you tell me about an experience or experiences you have had with Aboriginal peoples as a registered nurse?
12. Can you describe an incident you witnessed where you felt that an Aboriginal person might not have felt safe? What factors contributed to their discomfort? Why? Did you have any ability to intervene or make the situation safer? Why or why not? What happened next?
13. What practices do you think support Aboriginal patients? Are there ways to minimize the power differential between nurse and patient?
14. Is there anything else you would like to tell me about any of the subjects we have spoken about today?

Appendix D2: Draft Interview Questions for Others

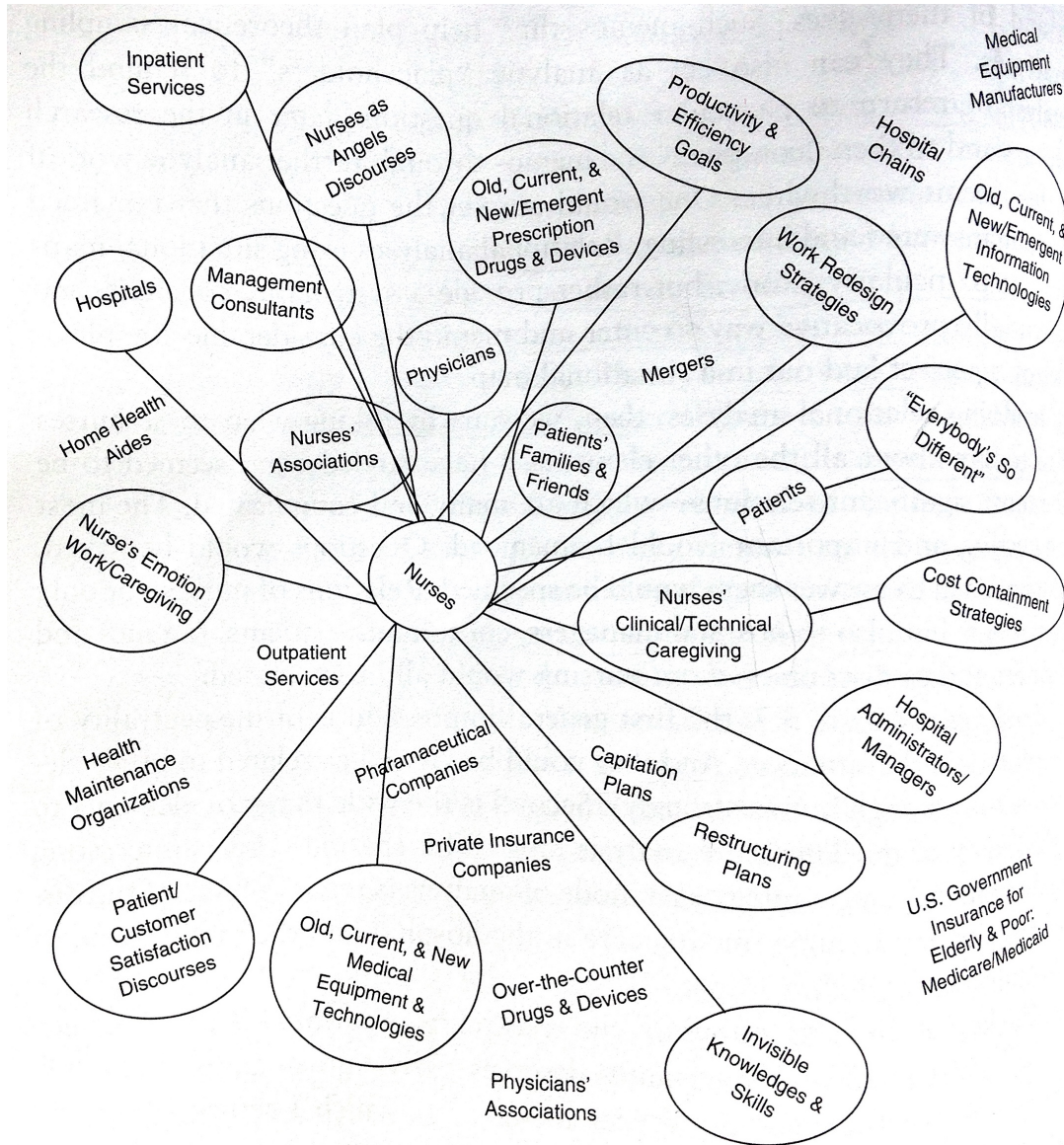
1. Name
2. What is your current position?
3. How long have you been in this position?
4. How long have you worked in the health care field? What other positions in health care have you held?
5. Are you familiar with cultural safety? How would you define it?
6. Prior to working in health care, what involvement, if any, did you have with Aboriginal peoples?
7. What source did your information about Aboriginal people come from (News media, community, school, family, friends)?
8. Have you had any educational opportunities in regards to working with Aboriginal peoples? If yes, what motivated you to attend? Can you tell me what you learned and what was helpful?
9. From your perspective, what challenges do health care providers face when working with Aboriginal peoples? Are these challenges different for new nurses? Have you noticed that some new nurses handle these situations more easily than others? Why or why not?
10. Would you say that this work environment is supportive of culturally safe practice? Why or why not?
11. Is there anything else you would like to tell me about any of the subjects we have spoken about today?

Appendix E1: Examples of Adele Clarke's Messy and Ordered Situational Maps



Source: Clarke, A. E. (2009, pp. 217-218)

Appendix E2:
Example of Adele Clarke's Relational Analysis Using Situational Map



Relational Analysis Using Situational Map: Focus on Nurses' Work Under Managed Care

Source: Clarke, A. E. (2005, pp. 104)