Developing Supportive Workplace & Educational Environments for Aboriginal Nurses

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Main Messages

- The cultures of Aboriginal people differ greatly, as does individuals' knowledge about them. So, similarity should not be assumed in either regard. It is unfair to expect nursing students or working nurses to be experts about a non-existent pan-Aboriginal culture, although this happens on a routine basis.

- The majority of colleges and universities offer some components of their nursing curricula *via* distance education. However, Aboriginal targeted marketing of this fact is needed. It is an option that will appeal to potential students, especially those who are older and have family responsibilities, or who live in rural/remote areas and are intimidated by the thought of studying in an urban centre.

- It is important to link students to academic and psycho-social supports in a deliberate way from the outset, rather than assuming that they will find needed services on their own.

- Schools of nursing should consider developing curricula based on the Aboriginal cultural competence and cultural safety framework for First Nations, Inuit, and Métis Nursing created by the Aboriginal Nurses Association of Canada, the Canadian Association of Schools of Nursing, and the Canadian Nurses Association.

- Employers should provide in-service education of sufficient depth and breadth so that all staff members are familiar with cultural features of the Aboriginal groups predominant in their catchment area, as well as the social, political and historical factors that may affect their health and well being. This will benefit nurses, other staff and clients of Aboriginal heritage.

- Employers should not rely on general harassment, bullying or discrimination policies to protect Aboriginal nurses or other staff in the workplace. Aboriginal-specific provisions should be developed to make such protections explicit.

- Employers should ask Aboriginal nurses on staff what is needed to make their specific workplace one where they feel welcome and where they know their cultural and nursing knowledge are both respected.

- A lot is being done by the schools of nursing at Ontario's colleges and universities to attract and keep Aboriginal students. So, too, employers across the health system encourage the recruitment of First Nations, Inuit and Métis nurses in the belief that they will benefit clients of similar heritage. Still, Aboriginal people in both sectors have unmet needs that require further attention.

Executive Summary

The exact numbers of nurses and nursing students of Aboriginal heritage in Ontario are not known, but they are disproportionately small relative to the size of the Aboriginal population. To increase the participation of First Nations, Inuit and Métis people in the nursing workforce requires supportive education and work environments where individuals feel safe, respected and in which cultural understandings of health are valued. This study asks what Aboriginal students and nurses themselves believe is essential to make work and school places where they feel welcome and their cultural interpretations are acknowledged. It also documents the challenges of creating such environments, and the strategies to do so in use by schools of nursing and health organizations serving significant Aboriginal populations.

The project was undertaken in collaboration with the Aboriginal Nurses Association of Canada, the Métis Nation of Ontario, the Registered Practical Nurses Association of Ontario, the Sioux Lookout Health Authority, and the North West Local Health Integration Network. Each of these groups was represented on the six member steering committee (along with a nurse educator) that guided the research team, which itself included nurses of Aboriginal heritage. Two of the project research assistants, who did most of the interviews, were First Nations members. Data came from 94 in-depth, open-ended interviews with Aboriginal nursing students and practicing nurses, nursing educators and supervisors or health system administrators.

The traditional beliefs, customs and practices of First Nations, Inuit and Métis Canadians vary considerably, depending on their people's territory and tribal history. However, non-Aboriginal colleagues and supervisors may believe that the Aboriginal nurses with whom they work have cultural knowledge that is pan-Aboriginal in nature. Further, it may be assumed that their mere presence will meet the cultural needs of Aboriginal clients. So they are relied upon as *the Aboriginal experts*. In fact, while these nurses may understand the importance of culture in

care, their specific knowledge will likely pertain to their own cultural group to a large extent. Moreover, many of the nurses said they were not knowledgeable about their people's traditions, or, as Christians, felt ambivalent about some of the spiritual beliefs. Nonetheless, when asked by clients or colleagues, the nurses helped as best they could. For example, they might teach others a few phrases of greeting in the local dialect (if they know it).

Nurses' cultural knowledge shapes their practice in four ways: tolerance, advocacy, boundaries and interventions. It gives them greater tolerance and willingness to accommodate clients' culture-linked preferences, even when doing so interferes with usual care giving activities. It also gives them a basis for advocating on behalf of clients, as happened when a maternity nurse intervened to ensure that a miscarried foetus was given to the parents for burial, rather than handled as biomedical waste. However, traditional beliefs can restrict their practice; in one instance a pregnant nurse declined to work in palliative care, in case a death occurred, because of a time-honoured belief that seeing a dead body might endanger her unborn child. Finally, in light of their cultural understanding, these nurses interpretation of symptoms may differ, particularly in the domain of mental health.

The vision statements of most health care facilities embrace inclusive ideals. But often these are not made real in practice. There is a tendency to rely on general policies to protect staff members against workplace harassment, discrimination or bullying. However, Aboriginal-specific policy provisions would reduce the likelihood of prejudicial interpretations under broad policies; for example, Aboriginal spiritual beliefs should be explicitly protected under the right of religious freedom.

Students report supportive faculty and generally good relations with their peers. And faculty members laud the contributions Aboriginal students made in the classroom. Unfortunate

incidents do occur; an illustrative situation involved non-Aboriginal students making statements that derive from hurtful stereotypes. Some instructors also turn to the Aboriginal students for answers whenever the questions are about Aboriginal health, which makes them feel uncomfortable. This is especially the case since so much of the relevant curricula are negative in nature, focusing on high rates of disease and violent death. Moreover, information is not contextualized, taking into account determinants of health or the assimilation policies of the post-colonial era (like residential schools). A better balance could be achieved by developing course content based on the cultural competence and cultural safety framework for First Nations, Inuit, and Métis Nursing, created in 2009 by the Aboriginal Nurses Association of Canada, the Canadian Association of Schools of Nursing, and the Canadian Nurses Association.

Certainly recruitment of more First Nations, Métis and Inuit people into nursing careers, and retaining those in practice, is essential. But their full participation can occur only in work environments where there is a deep understanding of the cultural dimensions of Aboriginal health, where Aboriginal nurses feel safe in sharing from their culture's perspective, confident that. Aboriginal ways of knowing are respected and welcome, and where their roles are not circumscribed by the assumptions of others. The situation in nursing education is the same. It is not sufficient to recruit Aboriginal students and, if needed, to provide special learning, counseling, or financial supports. Schools of nursing must be places that foster inclusion and encourage the exploration of Aboriginal knowledge and its application to practice.

The results of the study will inform educators and employers about what must be done to create and sustain supportive environments and, hence, recruit and retain Aboriginal students and nurses. Ultimately, Aboriginal clients will benefit from having more nurses who share some of their life experiences and worldviews.

Developing Supportive Workplace & Educational Environments for Aboriginal Nurses

Context

Ontario wants to increase the participation of Aboriginal people – *as Aboriginal people* – in the province's nursing workforce. Italics are added here to emphasize that this is not just a matter of numbers. Increasing participation also means that individuals are able to confidently contribute both their clinical knowledge as nurses and their cultural knowledge as Aboriginal people. Achieving this goal depends on understanding and overcoming the challenges that First Nation, Inuit and Métis individuals often encounter in nursing education and practice. Recruitment and retention – both school and employment – require supportive environments where individuals feel safe, respected and in which cultural understandings of health are valued. The authors believe this study will contribute significantly to the knowledge required to create such environments. By asking nursing students, registered nurses and registered practical nurses of Aboriginal heritage to reflect on their preparation for practice and their on-the-job experiences, it identifies learning and practice needs that are unique to their respective cultural groups. In addition, the organizational challenges involved are addressed through interviews with nursing school administrators/faculty and nursing supervisors/managers/administrators at health care facilities where developing and maintaining Aboriginal-specific supportive environments for staff and clients are priorities.

Aboriginal health human resources research tends to have a deficit orientation, for example, looking at the barriers to educational success. In contrast, by focusing on educational and workplace environments that encourage and sustain Aboriginal participation in nursing, the present study takes a strengths-based, solution oriented approach. Moreover, it shifts from the usual supply (low) / demand (high) analyses of practitioners or students, to look at the relational processes involved in Aboriginal nursing education and practice. This is in keeping with recruitment and retention strategies that encompass the concept of cultural safety, like the

nursing education framework proposed by one of our partners, the Aboriginal Nurses Association of Canada, along with the Canadian Association of Schools of Nursing and the Canadian Nurses Association.

The study asks three questions: *1. What constitutes a supportive educational environment for Aboriginal nursing students? 2. What constitutes a supportive work environment for Aboriginal nurses? 3. Are cultural interpretations of health respected in nursing educational programs and workplaces?* As worded, these questions seem deceptively simple. But there are multiple dimensions to each one. The educational environment is not limited to the nursing program, but extends to the host institution as well. And acceptance of students' cultural input is not limited to offering Aboriginal perspectives, but takes into account differences in their style of learning and communication. Similarly, experiences in the workplace are determined not just by the attitudes and expectations of others, but by the nurses' application of their own cultural knowledge when providing care.

Although there are snapshot counts of Aboriginal nurses working in specific Ontario contexts, like First Nation reserve communities (Minore et al.. 2008), or reported as registered in Ontario Schools of Nursing (Gregory and Barsky, 2007), actual totals for the province are not known, since that would require systematic self-identification. Nonetheless, there is no reason to doubt the view that the number is small relative to the size of the Aboriginal population. The situation is the same in other Canadian jurisdictions (Kulig & Stewart, 2006). Such shortages create particular challenges for the health care system. There is general recognition that Aboriginal clients often have unique care needs that require both clinical and cultural competence (Hunter et al., 2004). Recruitment of more people of Aboriginal heritage into the profession is widely seen as the best way of meeting this dual competency imperative (Minore et

al., 2007). For the same reason, there is a need to retain those who are currently in practice (Stewart et al., 2006). Having more First Nations, Inuit, and Métis nurses, especially in leadership positions, would help foster Aboriginal friendly work environments and create role models (Nichols, 2004).

Concerted efforts have been made to increase Aboriginal enrolment in nursing programs in Canada (Ontario, 2005; British Columbia, 2007; Anonson, Desjarlais, Whiteman, & Bird, 2008), including a significant investment through Health Canada's five-year Aboriginal Health Human Resources Initiative created in 2005. While some programs are relatively recent, a few have lengthy track records. For example, to improve the chances of student success, the Native Nurses Entry Program was established at Lakehead University in 1987. This one-year preparatory program was the first one in Canada that enabled Aboriginal students' direct entry into a School of Nursing. The University of Saskatchewan's Native Access Program to Nursing has a parallel history. In creating such post-secondary bridging opportunities, experience has shown that partnering with and taking direction from Aboriginal communities, organizations and people are keys to success (Wilson, 2008). This type of program offsets knowledge deficits that often date back to students' primary education at on-reserve schools. An alternate remedy would see better engagement of elementary and high school students in the math and science classes that are necessary for nursing school entry (Nursing Sector Study Corporation, 2004; Araluk, 2009).

In the case of regular practical nurse and nurse programs, Aboriginal students value instructor accessibility, flexibility, support and advocacy (Arnault-Pelletier, Brown, Desjarlais, &McBeth, 2006). They may have specific financial, learning or family care needs, and have to deal with non-acceptance on the part of non-Aboriginal classmates and instructors (Martin &

Kipling, 2006, Vukic et al., 2012). Schools vary, but most have dedicated resource centres which help students to cope by providing academic, social, and cultural support (National Aboriginal Health Association [NAHO], 2004; Hill, 2007). However, with exceptions (Arnold et al., 2008), cultural content of a type relevant to these learners (Curran, Solberg, LeFort, Fleet, & Hollett, 2008) is often missing from the curricula, or is inappropriately addressed from a western epistemological perspective (Kulig et al., 2010). To change this, the Aboriginal Nurses Association of Canada, the Canadian Association of Schools of Nursing, and the Canadian Nurses Association jointly developed the *Cultural Competence and Cultural Safety in Nursing Education: A Framework for First Nations, Inuit, and Métis Nursing* (Aboriginal Nurses Association of Canada [ANAC], 2009). A pilot project was undertaken at six schools to introduce new content based on the identified competencies; it is hoped that the results, published in 2011, will encourage wide-spread adoption of the framework (ANAC).

Research evidence suggests that Aboriginal students tend to conceptualize information holistically and visually, preferring learning environments that emphasize collaboration rather than competition (Hilberg & Tharp, 2002). A review of the literature on recruitment and retention of Aboriginal nursing students documents various strategies, like case-based group work, to increase levels of comfort, confidence and performance (Smith, McAlister, Tedford-Gold & Sullivan-Bentz, 2011).

As is the case for most new graduates, the transition to practice is challenging. They need help in navigating the job search and exam licensure process (McBride & Gregory, 2005), as well as in adapting to a new workplace (Wikaire & Ratima, 2011) or new role if they are returning to their home community (Katz, O'Neal, Strickland, & Doutrich, 2010).

Understanding the relational processes involved in Aboriginal nursing education and practice is essential (Browne & Varcoe, 2006; Simon, 2006). The nursing concept of cultural safety provides a powerful lens through which to examine the social, economic, political, historical and power dynamics underlying these processes (NAHO, 2008). First articulated in the 1980s by Māori nurse Irihapeti Ramsden (Ramsden, 2002), cultural safety requires that the provision of care to Indigenous peoples be contextualized, taking into account not only cultural distinctions, but also inequities that may affect provider-recipient interactions. In other words, "cultural safety finds expression in caring spaces that are equality seeking and rights oriented" (Dion Stout & Downey, 2006, p.327). This concept extends to Aboriginal nurses in the workplace and Aboriginal students in nursing programs. In either setting they need to feel that they are respected and that their perspectives are welcome and valued – they need to feel, in a word, *safe*. Failure to appreciate the importance of this can have profound effects. For example, every one of the inaugural group of 77 graduates from a Licensed Practical Nurses program for Aboriginal students left their first places of employment in the Prince Albert Health Region, a pattern that changed for succeeding cohorts of graduates only when cultural awareness training was introduced in these workplaces (Saskatchewan Institute of Public Policy, 2007).

Implications

Ontario's educational institutions and health sector employers understand the importance of having more Aboriginal people involved in the nursing profession. This is evident in the study results, which show that significant efforts are made to attract and keep those of First Nations, Inuit and Métis heritage both in school and at work. For example, there are several strategies in place at various schools of nursing designed to facilitate entry and success: a year-long preparatory program, designated seats for Aboriginal students, Aboriginal identified

applications; and curricula based on a recognized cultural competence and safety framework. Similarly, believing that their Aboriginal clients like receiving care from others whom they assume know about their cultures and ways of life, workplaces welcome Aboriginal nurses, although preferential recruitment is constrained by equity legislation and union agreements. Despite the general receptiveness and specific efforts to made education and employment settings safe and welcoming environments, however, the study identifies areas where more needs to be done.

There are particular implications of the study for both domains. This section addresses education sector considerations first, and then those that pertain to the workplace. Before doing so, however, there is one overarching consideration. That is the conception people have about the nature of Aboriginal cultures. Educators and employers must guard against assuming there is homogeneity in content and that all Aboriginal people share this common knowledge. Practices and beliefs vary considerably, shaped by geographical and tribal factors. Individuals may know their own people's customs, but they should not be called on as some sort of omni-cultural experts, either in the classroom or at work. Indeed, they may not know or wish to follow their traditions. Being turned to as a source of information by instructors, fellow students or colleagues can create feelings of discomfort, although those interviewed tried to meet such expectations to the best of their ability. Bearing cultural specificity in mind, it is also important to always consider the social, political, legal, and historical factors that impact Aboriginal people's health and well-being.

Entering a nursing program is a daunting experience for many Aboriginal students, but particularly for those from rural or remote areas. Consequently, there is a pressing need to link them with a support system from the outset. Interviewees suggested a dual strategy to

accomplish this; the use of peer navigators (more senior Aboriginal nursing students) who are familiar with the program, the institution, and the town, along with designated faculty advisors. The latter will need to address more than program requirements. They must know what academic, psycho-social and financial supports – Aboriginal-specific and general – are available through the college or university. They also have to know the resources present in the larger community, such as those provided through the Ontario Native Women's Association or Native Friendship Centres. A designated advisor can keep abreast of the individual's entire situation, taking into account personal as well as academic stressors. For example, many Aboriginals enter nursing programs as mature students, so they have family obligations, like needing to take time off school to care for a sick child. Having a supportive advisor who fully understands their circumstances can help them, perhaps by alerting colleagues as to why a student is absent or experiencing unusual difficulties in class.

Nursing curricula on Aboriginal health tends to have a problem orientation. Focusing on high rates of diseases such as diabetes, or youth mortality due to accidents and suicides, fails to recognize the many strengths that contribute to improved conditions, like the locally created programs to help those dealing with prescription drug addiction now found in First Nations across the northern part of the province. Aboriginal students report being distressed by this lack of balance in course content. Moreover, any information presented needs context, so it takes into account determinants of health, such as housing conditions, and the history of post-colonial policies that have damaged generations of First Nations, Inuit and Métis lives. Schools of nursing are encouraged to consider adopting course content based on the cultural competence and cultural safety framework developed by the Aboriginal Nurses Association of Canada, the Canadian Association of Schools of Nursing, and the Canadian Nurses Association.

There appears to be broad consensus that Aboriginal people share a particular approach to learning. Specifically this involves conceptualizing issues in their totality, rather than thinking about their constituent parts separately. They also tend to be visual learners. And, finally, they learn best through collaborative efforts rather than individually. With reference to the latter approach, there is an explicit dislike of the competitiveness typified by people comparing marks with one another. Instructors should consider modes of teaching that incorporate a holistic, visual and collaborative learning style. Non-indigenous students may also find such approaches preferable to having material presented in conventional lecture format.

The locus of delivery is important, too. Many of those interviewed, both students and practicing nurses, entered school as mature students. A lot also came from rural or remote places. Going to school meant a rupture in their way of living and personal support network. To alleviate this problem, schools should augment the delivery of curricula *via* distance education as much as possible, letting Aboriginal nursing students study closer to home. At least 26 schools currently offer some parts of their programs through distance modalities. However, the extent to which this idea was endorsed by students, nurses and professors suggests that the options are not well known. Schools could reach out to potential Aboriginal students through targeted advertising.

We turn now to the enhancement of cultural competence and creation of cultural safety in places where nurses work. Information on the social, political and historical factors that shape the lives of most Aboriginal peoples, together with details about the cultures prevalent in their catchment area, should be essential components of in-service training for all staff anywhere Aboriginal people are present. The depth and breadth of this knowledge will effect relations with Aboriginal clients and co-workers. It also may inform diagnoses and plans of care. For example, if clinicians at a tertiary centre know that staffing shortages are common at nursing stations on

reserve, they may not recommend that home care nursing be provided when clients return to their community.

Care settings where the Aboriginal client base is proportionately small, like general hospitals, are making efforts to accommodate traditional practices (i.e. providing well-ventilated spaces where smudging can occur). However, institutions need to do more to educate staff about their use and the significance of their existence. At present the burden of explanation falls on Aboriginal staff members; some are comfortable with this, others are not. As well, they often have to advocate for bedridden clients who want to honour their customs, even if this upsets routine or creates minor inconveniences. Employers must support the flexible interpretation of policies to accommodate the integration of traditional practices with western modes of treatment. Nurses need to feel confident that they will be supported if they use their own cultural beliefs, or those of the client, when these are appropriate, complimentary and not contra-indicated medically.

Most institutions do have inclusive vision statements, but to translate them into action may require the adoption of cultural group specific directives. In most cases it is assumed that the general policies in place to deal with harassment, bullying or discrimination in the workplace apply to all and provide sufficient protection. But would traditional spiritual practices be regarded as religion beliefs and therefore included? Probably, or at least it is hoped so, but much better to have this fact acknowledged in writing. Similarly, employers should not assume Aboriginal nurses are shielded by virtue of the standards of practice in their colleagues' respective professions regulatory colleges.

It is not surprising that Aboriginal run facilities appear to have stronger, more integrated safeguards in place. Aboriginal nurses employed there seem to know their clinical and cultural

knowledge is valued by their clients, colleagues and employers. The largest challenge for those who do community outreach is enduring bystander hostility when they are dealing with street involved clients. In contrast to most workplaces, the administration of these facilities must guard against actions that can be perceived as preferential treatment for Aboriginal employees, in order to avoid damaging inter-professional team relations (when there are non-Aboriginals on the team).

Approach

A six member project steering committee, including representatives from Aboriginal organizations, nursing organizations, nurse educators, employers and regional decision-makers guided the implementation and execution of the project. The study itself employed a multi-step research strategy, involving the following activities: (i) a comprehensive review of the literature on the workplace and educational experiences of Aboriginal nurses; (ii) interviews with Aboriginal nurses who are currently employed in Ontario to determine their perceptions about supportive workplace and educational environments; (iii) interviews with Aboriginal students who are currently enrolled in Ontario's nursing, practical nursing, nurse practitioner and Aboriginal nursing access programs; (iv) interviews with nursing education instructors and program administrators; and (v) interviews with administrators, nursing supervisors and managers at five health care organizations serving significant populations of Aboriginal clients through clinical and/or community programs. These are Six Nations Health Services, Sioux Lookout Meno Ya Win Health Centre, the Wassay Gezhig Na Nahn Dah We Igamig Aboriginal Health Access Centre in Kenora, North Bay General Hospital, and Kingston General Hospital, respectively.

A total of 94 in-depth interviews were done, including 30 nurses from across the province, 24 students and faculty from 16 nursing programs, and 40 administrators/ supervisors/managers. Interview data were analyzed using inductive procedures whereby the volume of information collected is reduced by focusing on recurring ideas and their relationships with one another. Sensitizing concepts derived from the literature review informed the analysis and helped to identify new or emergent categories in the data.

The study was undertaken in partnership with the Aboriginal Nurses Association of Canada, the Sioux Lookout First Nations Health Authority, the Métis Nation of Ontario, the Registered Practical Nurses Association of Ontario, and the North West Local Health Integration Network. These collaborating organizations were represented on the project steering committee.

Results

The presentation of findings is organized according to the study questions. There is one thing, however, that bears on each topic. Knowing who is Aboriginal depends on individuals identifying themselves as such. They may choose not to do so for many reasons: because they do not see it as relevant to their role as students or nurses; because it is not a major part of how they see themselves; or because they fear encountering racism. They may even be unaware of their heritage. Consequently, both educators and employers are uncertain about the racial status of those with whom they interact. This can translate into hesitancy about what supportive policies and practices are needed.

Liberal use is made of direct quotes from the key informant interviews in the following summary of results. There are three reasons for using people's own words: first, this best captures the tone of their comments; second, it ensures that their views are reflected accurately; and, third, often the interviewees' words make a point most forcefully.

What constitutes a supportive educational environment for Aboriginal nursing students?

Not unlike many students, those interviewed were inspired to pursue a career in nursing by role models within their families or nurses observed in action. But they had another motive as well: a strongly held wish to serve their own people. As individuals, however, they followed different pathways into their nursing studies; some entered directly after high school, many others as mature students. A notable number also report "going the long way around," starting in practical nursing and, later, undertaking BScN programs. Because of the multiple routes taken, colleges and universities need to adopt diverse recruitment strategies, using tools like social media and job fairs to reach those who have already left school, as well as working with high school guidance counselors and teachers.

Entering post-secondary programs can be an unnerving experience, particularly for Métis or First Nation people used to life in rural or remote communities. They need a strong support system from the first day. Ontario's colleges and universities recognize this and provide various types of help through dedicated resource centres. A typical example is the Native Centre at one college: "where you can access counseling, where they have smudging and spiritual teachings, a quiet place to work, just somewhere you can go where people understand you." In addition to centres open to Aboriginals from all programs, some nursing schools maintain spaces specifically for the use of their own students. These serve as informal drop-in spots, but have staff able to assist with academic as well as personal matters, such as finding suitable housing and childcare (since so many are mature students). Those enjoying nursing only facilities found the companionship of others with similar backgrounds and experiences particularly beneficial: "We just chat over stuff that we've been through . . . we support each other a lot." Both types of centres also help students navigate access to Aboriginal programs available outside the

institution, like those at local Native Friendship Centres. Among the nurses interviewed, graduates from before the mid-1990s remember the existence of little Aboriginal-specific assistance. That has clearly changed; nonetheless, in grading their university's efforts, a faculty member judged: "out of 10, I would say it's a 5 . . . we have a lot more work to do."

Current students and nurses remembering their college or university days generally praise faculty members, whom they found approachable and encouraging, people who "really do want you to succeed." They even name professors who helped them through crises of confidence about their academic work. Key to such positive relations was the fact that these faculty members were aware of students' personal situations, including external stressors, and dealt with them as individuals. The one source of discontent mentioned by students occurs in the class room, when instructors expect them to answer any questions related to Aboriginal health. One person summed the situation up simply: "It made me feel very uncomfortable."

Too often content about Aboriginal health in curricula is not balanced. A number of interviewees complained about the focus on problems, "depicting those poor little Indians" with their high morbidity and mortality rates. Further, they note, the negative facts are not contextualized through discussion of social, political or historical issues. "You don't want to always be talking about deficits . . . you want to talk about strengths . . . you want cultural safety." Guidance about appropriate materials now exists. The framework for cultural competence and cultural safety (cited above) is available on the websites of each of the organizations that collaborated in its creation. The framework identifies the core competencies (post-colonial understanding; communication; inclusivity; respect; indigenous knowledge; and, mentoring and supporting students for success) and the structures (community engagement/collaboration; supports for students) required to achieve the necessary levels of

awareness among students – Aboriginal and non-Aboriginal – and faculty alike. The Schools of Nursing at Trent and Laurentian took part in the pilot test of the framework. It the case of the latter, for example, a five module practice guideline was produced as a resource for students and basis for curriculum development.

The holistic/visual approach to learning, referred to in the literature, also effects students' success. One example, offered by a professor, involved an essay where an Aboriginal student introduced seemingly irrelevant ideas that actually reflected dimensions of the issue from a First Nation community perspective. If there was a fixed grading scheme based on the *right* answer, the teacher noted: "She would not have done very well on that assignment." Effective instruction requires flexibility and an appreciation that students may conceptualize things as a totality rather than departmentally, which is a more common approach among non-Aboriginal learners. Consequently, they process information differently, sometimes taking longer to reach an answer, although the end result will be sound. In talking about this, one First Nation nurse said: "our brains work differently, but when something is made applicable to us, then we can excel."

Students are sometimes confronted by antagonistic classmates who assume that they all enjoy "a free ride" through school. Funding arrangements for Aboriginal students are complex. Some First Nation people are supported from a federal government subsidy allocated through their home communities. Many are not. They do not qualify or there is not enough money to go around. Like those of Métis ancestry (and students generally) they must rely on their own/family incomes, scholarships or bursaries and loans. It was noted that this misperception can follow people into the workforce. "My co-workers can be a little rude, just [because] of their knowledge that our education is funded through the government."

Students, especially those from rural or remote communities, may feel forced out of their comfort zone and cut off from everything that is familiar when they leave for college or university. Acknowledging this fact, interviewees in every category suggest the structuring of curricula delivery to maximize use of distance education, enabling learners to spend more time in their home communities. At least some components of the programs at 26 schools in the province are available this way, either *via* online courses or, in a few cases through rural site offerings. The uptake among Aboriginal students is unknown, although the frequency with which it was identified as a needed alternative suggests, at least, that awareness of the option could improve.

What constitutes a supportive work environment for Aboriginal nurses?

To a large extent the nurses interviewed report working in inter-professional teams that function well together, where everyone is treated equally, fairly and respectfully. This was the case in hospitals and community-based settings. Nonetheless, there are also points of contention. For example, although they may feel accepted themselves, nurses find their non-Aboriginal colleagues use negative stereotypes when referring to Aboriginal clients, particularly those who are street involved. Or do clinical assessments focusing only on signs and symptoms, ignoring relevant determinants of health that should be considered, "like mould in their housing and contaminated water supplies." There were also remarks made that were subtle, yet essentially racist, such as asking someone working in a large city hospital whether they had to pay income tax since they lived on a nearby reserve. But only one openly racist instance was reported. In that case colleagues made fun of an Aboriginal nurse honouring their traditions. To the seeming amusement of the non-Aboriginals who were there, this person was continuing to talk to a

recently deceased Elder, addressing his still present spirit. Their taunting remarks – "You know he's dead? He can't hear you!" – were demeaning and humiliating. A quite different impediment to good team relations is the perception on the part of non-Aboriginal colleagues that Aboriginal nurses enjoy privileges not available to others. For example, some employers allow their Aboriginal staff members time off on cultural days just as they do for everyone on other religious holidays (schedules permitting). This is seen as unfair and causes discord within the team.

The latter situation underscores the fact that the nurses interviewed were employed in all types of care settings: remote community nursing stations; Aboriginal Health Access Centres; with Family Health Teams in primary care clinics; general hospitals; and health science centres. Consequently, the proportion of Aboriginal clients and colleagues varied significantly. So, too, the administrative structures within which they work.

Talking about the use of syllabics on signage throughout their general hospital, an administrator said: "It's a symbol that this organization supports and acknowledges the needs of Aboriginal people, [whether] as a patient or as a staff member." But do the symbols reflect reality so that clients are trustful and staff, in this case nurses, feel valued? Certainly there is a sense that Aboriginal caregivers are important from the clients' point-of-view. A nurse at another hospital reports: "Everybody gets really excited when someone joins us who is First Nations, because it means so much to the clients." Such a statement does not imply First Nations, Inuit and Métis people will only accept the attention of Aboriginal clinicians; just that the latter lend a measure of familiarity and, therefore, reassurance. Achieving the desired situation depends on interactions within the health care team as well as a number of employer policies and human resource regulations.

A unique set of challenges face those employed at nursing stations, particularly in their home communities. Indeed, some surprise was expressed about nurses being willing to return home, since they know from their youth that the nursing stations are chronically understaffed, creating heavier workloads than found elsewhere. Once back, they must negotiate acceptance in their role as a nurse among people who see them first and foremost as a neighbour. So they may find resistance from clients concerned about them maintaining confidentiality or about their competence (since they were known as children). Most difficult, however, is dealing with community leaders or members who expect them to act beyond their scope of practice. Those asking do not understand why the nurses do not comply and their anger can poison the nurses' relations with the community as a whole.

While Aboriginal run health facilities would seem to offer ideal working environments, poor relations between administrators and clinical staff can create difficulties. The interviewees talked about both positive and negative situations, although more good than bad. Perhaps surprising, none of the organizations mentioned provides new recruits with information about the cultures that are predominant among their clients. "I think it's hard for the nurses that are coming in, because there's very little in terms of cultural teaching for them." This is a significant gap given the likelihood that the nurses come from different cultural backgrounds.

Places where the client population is mixed tend to receive poorer marks on questions about supportive workplace environments. With exceptions, like Sioux Lookout Meno Ya Win Health Centre, hospitals are criticized for the lack of cultural awareness and sensitivity evident, although it is conceded that more of them now have dedicated spaces where people can smudge (without setting off fire alarms) or engage in other spiritual practices. But a nurse, who works at a large health sciences centre where such facilities exist, feels: "most of my colleagues still have

no understanding of Aboriginal culture or Aboriginal beliefs and why the smudging is important." At another hospital, an administrator reported "some of the nurses will . . . look into these things on their own, but we don't do it collectively and we need to, given that [Aboriginals] are one of the populations we see regularly." Overall it seems that institutional mission statements are inclusive, but these do not translate into Aboriginal-specific policies for either employees or clients. It is assumed that general policies on matters like harassment, fairness or bullying in the workplace apply and are sufficient to protect all. As well, it is thought the standards set by the various disciplines' regulatory colleges cover these matters. However, administrators also admit that errors and omissions likely occur. "We could be doing stuff we're not even aware that they perceive as not supportive." Program managers and nursing supervisors expressed interest in finding out exactly what policies their Aboriginal nurses want and how to develop them.

Employment policies have to respect the law. Moreover, union contracts exist at many facilities. So, for example, situations cannot arise where continuing education incentives are provided for one group if they are not available to others who are similarly qualified. Nor can employers use restrictive language, like "Aboriginals preferred," when advertising positions. Decisions are based on the competence of applicants. Other things being equal, however, Aboriginal status is considered an asset. Some concern was expressed at an Aboriginal organization that, given client preferences, "we'll take a new grad and we'll try to fit them into an advanced nursing role, [which] is very hard on that nurse."

Are cultural interpretations of health respected in nursing educational programs and workplaces?

The misapprehension that there is homogeneity in the content of Aboriginal cultures and, by virtue of their racial background, that all Aboriginal people are carriers of this common knowledge creates difficulties for them in both educational and workplace settings. Practices and beliefs are tribal and often local or territorial. Speaking about cultural differences, a First Nation nurse, who grew up in the north but worked in the south, observed: "where my family comes from the traditional pursuits are in the hunting, trapping, fishing and crafts. [For] southern people it is more being able to practice their ceremonies and their spirituality." So an individual may recognize the importance of cultural knowledge in providing care to other Aboriginal people, and she or he may know their own tribe's customs, but they cannot be called upon as some sort of pan-Aboriginal cultural experts in the classroom or workplace. Indeed, they may not know their own traditions or believe in them, particularly those who have discovered their racial identity as adults. One nurse talked about the personal challenge for her as a Christian, in trying to support clients in their pursuit of spiritual solace through traditional practices. Of course, "not all Native [clients] practice the Native traditions," although they may be more comfortable with nurses of the same ancestry. While these facts do not diminish the overall importance of having more Aboriginal people in the nursing workforce, they caution against assuming that a shared cultural knowledge exists, independent of individuals' experiences.

Faculty members feel that Aboriginal students enrich a course by talking about their communities, their values and how they interact with one another. It is conceded, however, that non-Aboriginal peers sometimes react with impatience if they think the information is tangential to the topic at hand. Incidences of open hostility are reported. In one case, the student was

accused of “blaming the white people again for all the problems that [your people] ever had.” Other types of situation also generate hard feelings. For example, a class presentation by non-Aboriginal students, intended to stimulate discussion, made use of hurtful stereotypes and lead to an unpleasant confrontation. In that instance, other non-Aboriginals in the class rallied to their defence, which heartened the Aboriginal students. Interviewees also report positive relationships among classmates and point to examples where both groups benefit from their friendships. One such occasion occurred in a clinical area, when Aboriginal clients who were reluctant to interact with the non-Aboriginal students became receptive once they observed how comfortably all of the students in the group were with one another. Nonetheless, encountering overt or covert racism in their learning environment undermines the confidence of First Nations, Métis and Inuit students.

In clinical settings co-workers do rely on Aboriginal nurses for help when they have Aboriginal clients. “My colleagues will come and get me and I’ll go talk with the person.” They also ask genuinely interested questions about the traditional beliefs and way of life. If the Aboriginal nurses know the language commonly used by the client group, they may teach their associates a few salutary phrases, so clients feel welcome and respected. Team members also turn to these nurses for help in pronouncing names, which sometimes combine letters in ways that are not usual in English. Those interviewed generally felt comfortable being asked for their input, although are concerned when the clients in question come from their own community. “I have to be careful not to be involved if it violates their confidentiality . . . which it’s very difficult to do,” because the clients may not understand the reasons for this disengagement.

Aboriginal nurses cultural knowledge effects several dimensions of their practice: tolerance, advocacy, boundaries, and interventions. The first of these, tolerance of client actions

reflects an ability to balance institutional rules with client expectations. An example was given by a nurse working in the emergency room. Whereas, their colleagues would insist on *only one visitor at a time* they understood the importance of allowing several family members to attend their loved one together, even if it inconvenienced care giving to some extent (when infection control was not an issue). The second dimension, advocating on clients' behalf, is common. An illustrative case occurred after the death of an Elder in hospital. As is their people's custom, the deceased's relatives needed to smudge in the room where she died. They were told they could not do so because it would set off the fire alarm, but an Aboriginal nurse on the ward said: "phone maintenance and get them to shut that off . . . [the family] has to do it and they're not going to leave here before they do it." The third issue, the boundaries set by nurses based on their personal beliefs may restrict what they are prepared to do on the job. One such instance happened while a nurse was pregnant; she refused to care for palliative patients for fear that they might pass away on her shift and "my belief is, well most Aboriginals believe that you're not suppose to see a deceased body when you're pregnant." The fourth aspect, bringing culture to bear on clinical interventions, is essentially one of educating colleagues about their interpretations. A situation where a client claimed to see bear walkers elicited a diagnosis "she's just delusional, she is seeing things." The nurse in this case explained that such sightings did not indicate a deviation in the client's mental health, but needed to be understood as normal within the person's culture. Another example given was the handling of a foetus lost through miscarriage; while usual hospital procedures would have treated it as biomedical waste, an Aboriginal maternity nurse intervened to ensure that the parents were able to have a proper burial ceremony in their home community.

The ways traditional medicine is incorporated into western health treatment reflect the nature of the workplace. It is not surprising that Aboriginal run facilities enable the greatest integration of the two approaches by providing spaces to use for locally appropriate ceremonies, such as sweat lodges. Clients' conditions are also a determinant. An example is provided by a mental health nurse who is able to take her First Nation clients to pow-wows and celebratory feasts on a nearby reserve. However, most often the nurses try to manage the integration through respectful communication with clients. So the diabetic client, who prefers his own ways, could be told: "Well, just to complement the traditional medicines, consider taking your Metformin." A nurse practitioner elaborated on this point using the case of someone with strep throat. The NP would order bark tea for them, but also penicillin. In other words, these nurses follow best practice guidelines, but try to include traditional healing methods as well. It is one way in which the dual competence imperative is met, combining their cultural knowledge as Aboriginal people with their scientific evidence-based nursing knowledge. Sometimes their efforts are questioned, as happened when nurses from one diabetes program, who allowed clients to eat bannock once a week, were challenged by their supervisor.

Individuals are mindful of the regulatory environment in which they work, and the need to practice according to the standards set by the College of Nurses of Ontario. In this light they ponder: "if a certain [traditional] treatment didn't work . . . how the College would see that . . . if it's not a best practice?" In fact, the college's practice guideline for culturally sensitive care does encourage the incorporation of traditional medicine when desired by clients who are of First Nations, Métis or Inuit heritage. Certainly, health system administrators are concerned about ensuring that their Aboriginal clients have the best possible healthcare. To that end many

institutions – Aboriginal and non-Aboriginal alike – support nurses' pursuit of specialty certification in areas like the treatment of diabetes.

Clearly a number of specific issues remain to be resolved, but overall it seems that educators and employers are receptive to including Aboriginal interpretations of health in the classroom and delivery of care. While faculty, peers, employers and co-workers are well-intentioned and supportive, they are tripped up at times by faulty assumptions.

Further Research

Of course, creating nursing education and work environments where Aboriginal people feel comfortable and culturally safe is an important end in itself. But one factor on which this need is premised is the assumption that Aboriginal clients' value receiving care from others with whom they can relate based on a shared racial background. Intuitively this seems likely, and the present study shows it is a generally held belief. However, to our knowledge the premise has not been tested in a careful, systematic way. Future research might explore clients' perceptions of nursing care, perhaps focusing on the ways in which nurses enable clients to honour personal traditions in order to help them on their healing journeys.

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