

NURA 598: Practice Project

NO SHOW

The

stamp in Primary Health Care:
Making peace with a colonial legacy

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PRACTICE PROJECT

So what is it about us that you don't like?

You're probably thinking racism is the answer. Maybe.

Certainly, part of it is racism. Not the same brand of racism that created apartheid in South Africa or slavery and segregation in the United States. It's a kinder racism that is cut with a genuine fondness for Natives and Native culture, a racism infused with a suffocating paternalism that can gently strangle the life out of a people. To be sure, it is an affection that is most times misplaced, an affection that is focused on the more exotic, erotic, mysterious, and spiritual aspects of Native life... (p.145)

Thomas King *The Truth about Stories – A Native Narrative*

Introduction

The project *The “NO SHOW” stamp in Primary Health Care: Making peace with a colonial legacy* is the synthesis of my graduate experience in the Master of Nursing program – Advanced Practice Leadership option - at the University of Victoria School of Nursing. With this project, I have not only applied my learning in advanced nursing practice, but I have also explored aspects of my fields of interest in cross-cultural practice, Aboriginal health, and the intersection of peace and health. The project is divided in three parts: First, I will describe the context of the practice project and elaborate on its purpose and objectives. The second part of the project, starting with an abstract, is formatted as an article on the use of the “NO SHOW” stamp intended for publication in a journal. It contains the main analysis from this project. The third part is a policy briefing note in Appendix A, created to initiate change through this practice project. This note is written for policy makers in Nunavut and can serve as a template for decision makers in other jurisdictions.

Issue and Background

The issue I examined for this practice project is the practice of using a “NO SHOW” stamp to record the non-attendance of medical appointments in personal health records. I have personally witnessed this practice in various health centres in Canada’s North. It appears as a minute and insignificant part of nursing practice and health care delivery. However, as I argue in this project, it can carry significant connotations in cross-cultural practice if examined in a wider context. The no-show issue came to my attention because of my concerns for the implications of my personal and professional presence in Aboriginal communities over the last fifteen years. Over the years, I have reflected many times on my own role as a community member and my involvement in community development as well as in professional and government services. Was I a neutral bystander, an incidental witness, a willing supporter, a curious observer and learner, or an ignorant accomplice in ongoing genocidal actions against Aboriginal peoples in Canada – or a combination of all these aspects to varying degrees over time? My own uneasiness about the impact of my presence with Aboriginal communities in times of tense postcolonial relationships between the Aboriginal margin and the Canadian mainstream has only increased during my recent academic studies in nursing, intercultural education, and peace and conflict studies.

That personal uneasiness is based on the realization that – as a white Canadian living in a First Nations or Inuit community - I represent the dominant culture and by extension the past policies of overt colonization practices. It is also based on the increasing awareness that despite a changed rhetoric, enshrined in the official and

apparently inclusive discourse of Canadian multiculturalism¹, not all the legacies of the colonial past have magically disappeared. Some colonial legacies continue to be embedded in various government programs and services, including the delivery of health care (Waldram, Herring, & Young, 1995). Maybe that is part of what King (2003) calls “a kinder [form of] racism” (p. 145). I have been exploring the roots of my uneasiness throughout my academic studies, sharing my insights and findings about the kind of health nurses are promoting in cross-cultural practice (Arnold, 2004) and the importance of understanding worldviews and the ability to practice based on a diversity of paradigms (Arnold & Bruce, 2005). Influencing change has been easier on a personal than on an institutional level. As I will describe later, it is often difficult to address potential conflict areas in professional practice because of their subtle nature. I consider working towards such change as part of a personal commitment to peace building. Hence, I will emphasize peace-related word choices and their opposites, including a series of war theme headings in the second part of this project.

There are many obvious challenges for advanced practice nurses in the fields of Aboriginal health or remote nursing. Much effort is put into particular disease-specific issues and challenges, such as diabetes, tuberculosis, obesity, tobacco reduction, and sexual health. However, there seems to be limited interest to question whether a dominant ‘war on disease’ rhetoric – as Fitzhugh Mullan puts it - with health professionals becoming very efficient at being “single disease combat warriors” (Field, 2006,

¹ See Wood and Gilbert (2005) for a description of the ascendance and development of multiculturalism in Canada. These authors also offer an analysis of the congruence between the rhetoric and the socio-political reality of multiculturalism. The federal policy has created powerful symbolism but it has never been intended to radically transform its institutions.

1^h:09':33") is the best and only way to address health status and disparities such as the one's encountered by Aboriginal populations in Canada. The use of the "NO SHOW" stamp has registered with me as a practice that may be an expression of policies or attitudes among health care providers working in cross-cultural practice that is an extension of disease-specific expertise (for fighting a clearly identifiable pathogen or pathology) and an expression of the assertion of epistemological superiority. As an advanced practice nurse, I am interested in contributing to the critical analysis of such attitudes and assertions.

My initiative to examine the no-show discourse was triggered during a posting as Home and Community Care Nurse in Gjoa Haven, Nunavut between April and June 2008. During the daily morning report at the health centre, the discussion about "no-shows" appeared to be unavoidable. Depending on the composition of the health care team, the discussion was more or less lively. One of the recurring themes during the report was who did not show the day before. This would then lead into further discussion of who repeatedly does not honor medical appointments. Eventually, certain community members became defined as "no-shows" in the same generalizing way as people living with diabetes as "diabetics". Unfortunately, the same discussions surfaced during private, social gatherings of nurses in this remote community. The discourse, its frequency, and intensity were rarely challenged. Possible breaches of confidentiality and other professional standards in relation to the recurring and in my opinion excessive no-show discussions were quietly overlooked and never addressed.

I was faced with two dilemmas: First, I was an outsider at the health centre due to my role as Home and Community Care Nurse. As such, I was a guest during the morning

reports as were the Mental Health Nurse, the Social Worker, and the Community Health Representative. Missed appointments are less of an issue in the home care field and cannot be as easily labeled as no-show since it is the nurse who is supposed to show up at the client's residence. Secondly, I had a hard time speaking about the issue because of its complex and subtle nature. It was ineffective to simply ask nurses who got carried away to stop discussing clients in a nonprofessional way. Such a request could have easily been constructed as an interpersonal issue. The few times the no-show discourse was challenged in conversation, it was either laughed away as nothing serious. Alternately, it was rationalized as a shared experience and a universally accepted conversation topic for nurses working in the North. The difference to sports or fashion, which require supportive mass media to serve as almost universal conversation topics, is that proof of non-attendance was formally stamped in the respective personal health records. Quite literally, using a stamp and red ink².

At that time, I was not prepared to argue in an informed and knowledgeable way against the discussions that I deemed inappropriate. I was also not prepared to assess the merits of the underlying practice of using the "NO SHOW" stamp in the health centres for recording non-attendance for medical appointments. However, when it became time

² It is hard to deny that a certain similarity to the way the passports of Jewish people in Europe during the Third Reich period have been marked has influenced my reaction to the visual effect of the "NO SHOW" entries in personal health records. The idea of using a stamp to mark the passports was suggested by Swiss authorities to the Nazi regime in Germany in an attempt to streamline immigration and refugee procedures at their inner-European borders (Forsythe, 2005). No direct harm was intended or caused by the use of the "J" stamp. However, the implications of the practice have proven catastrophic for numerous people of Jewish origin.

to focus on the completion of my Master's studies and define a suitable issue for a practice project, I chose to explore the no-show issue.

Preparing the project proposal and conducting the preliminary literature search revealed to me that the no-show issue, the way in which I witnessed it, had not been previously subjected to a published scholarly discussion. Hence, there was little guidance in how to address the issue in a scholarly manner. A narrative of my experiences did not seem suitable for a systematic exploration. However, my own dilemmas and associated notions led me to the central questions for the project. I felt that the way some nurses engaged in the no-show discourse was counterproductive in working towards health and healing in Aboriginal communities. I could not reconcile the fact that outpost nurses who (1) have conscientiously chosen and prepared for their specialized practice area, (2) seem to care for Aboriginal peoples and to be interested in Aboriginal cultures, and (3) are the health care system's front line providers of programs and services, and (4) seek to improve Aboriginal health and to reduce the health disparities in Canada's North, could participate in said conversations. The nurses' attitudes towards a segment of the population they served appeared quite derogatory and hostile, or as King (2003) would ask: What is it about us that you don't like?

This is in opposition to the "assumption of therapeutic intent on the part of the nurse, and responsibility for achieving health outcomes through 'good' relationships" (Doane & Varcoe, 2007, p. 192). A widely known quote attributed to Ralph Waldo Emerson - "Peace cannot be achieved through violence, it can only be attained through understanding" (Wikiquote, 2009) - crossed my mind, mainly because I believe nurses cannot contribute to healing through arrogant or discriminatory attitudes and practices.

Furthermore, the rationale for using the “NO SHOW” stamp as a charting tool in a personal health record did not appear self-evident to me. I was left wondering how the one rubber stamp in a nurse’s desk is interconnected with the witnessed discussions.

Thus, the following two questions emerged: How do taken-for-granted ways health care professionals practice in a cross-cultural context with Aboriginal communities shape the experience and outcome of health? The second question was: How can I identify in a scholarly manner factors beyond the immediate medical and epidemiologic causes that may contribute to the significant health disparities encountered by Aboriginal populations in comparison to the general population in Canada?

It was easier to focus the project on a tangible tool rather than on nurses’ attitudes and behaviours. This focus eliminated the risk of getting lost in individual stories that could be deemed non-representative. I thought I could also avoid unjustifiable generalizations and stereotyping about a group of nurses. Instead, I chose to view the practice of using the “NO SHOW” stamp as a part of nursing culture. As such, the individual nurse retains the agency to adopt or reject that particular cultural aspect of practice. Addressing the phenomenon of concern as a cultural practice rather than as individual attitudes and behaviours is related to the postcolonial lens I apply to this inquiry.

Postcolonial theory is a reaction and resistance to the cultural legacies of colonialism. It is originally found in the literary tradition. Ashcroft, Griffiths, and Tiffin (1989) summarize that “assumptions about the universal features of language, epistemologies and value systems are all radically questioned by the practices of postcolonial writing” (¶1). A postcolonial lens has been used before to examine taken-

for-granted ways of practicing in the health care field, particularly in cross-cultural practice. Blackford (2003) found an exclusionary health care culture in cross-cultural settings in Australia. Her study showed that this health care culture is a result of government and institutional policies as well as professional practices. Blackford argues that looking at cultural phenomena through a critical lens, rather than a strictly anthropological one, allows the researcher “to connect with the broader socio-political context” (p. 238) under which such practices were established. I try to avoid a focus on the “exotic, erotic, mysterious, and spiritual aspects of Native life” (King, 2003, p. 145). By choosing a postcolonial lens, the direction of this project was established to focus on an upstream view, starting with the NO SHOW stamp and examining the institutions and circumstances that led to the establishment of the practice in question.

Unquestionably, along the downstream view there would be other worthwhile issues to explore. For example, the question of why clients miss or chose not to attend medical appointments is located along the downstream spectrum. From my observations in the Kitikmeot Health Centre, a significant number of missed appointments are due to a lack of effective communication from the nurses to the clients. After controlling for such operational reasons, it would be interesting to explore if there are any cultural factors specific to particular Aboriginal populations that influence the attendance rate. This question needs to be addressed in a future study. Within this project, focusing on examining the ‘Other’³ could easily distract from the inconvenient exploration and painful realizations of potentially racist connotations in taken-for-granted practices in order to improve cross-cultural practice. After all, the nursing gaze, an integral part of

³ See footnote 18.

contemporary nursing culture and an essential way of knowing with an implied standard of normality, is directed toward the patient (Ellefsen, Kim, & Ja Han, 2007). Therefore, it seems easier to identify or construct a deficit attributed to the other than critically questioning one's own practice and being as a potential source of an issue when examining a phenomenon of concern in the health field.

However, by choosing to focus this paper on the usage of the tool, I make it difficult to explore and describe it as a phenomenon of nursing science⁴. Instead, I pursue a more interdisciplinary approach. This is consistent with the nature of the issue that is not specific to nursing. Because the practice is so well established in the institutional culture, itinerant physicians and other health professionals who provide health services based at the local health centres also engage in the practice of using the stamp for recording non-attendance of their respective specialty appointments. Nonetheless, future research into how taken-for-granted health care practices in a cross-cultural context with Aboriginal communities shape the experience and outcome of health is very well suited to a thorough exploration from a nursing science point of view. Some of the themes and effects of using the “NO SHOW” stamp identified in this project – for instance paternalism – can provide a good starting point for future inquiry.

⁴ Nursing science, a basic science, is the substantive discipline-specific knowledge that focuses on the human-universe-health process articulated in the nursing frameworks and theories. The discipline-specific knowledge resides within schools of thought that reflect differing philosophical perspectives that give rise to ontological, epistemological, and methodological processes for the development and use of knowledge concerning nursing's unique phenomenon of concern. (Barrett, 2002)

For the analysis in this project, I use a framework that is not grounded in nursing science. McLuhan's framework, described in his book *Laws of Media* (McLuhan & McLuhan, 1988), provides a suitable platform to start a wide-ranging exploration of the "NO SHOW" stamp and the practice of its use in the health centres. I will elaborate on specific merits of this framework for this project in the main article. In retrospect, I cannot recall how I became aware of McLuhan's work for my practice project. Trying to understand his approach and exploring the tetrad of questions therein led me on a contemplative journey about human traits, the discourses of efficiency, labeling and stereotyping, law and order – just to name a few. I explored the principles of Primary Health Care, the roles of nurses and nursing, the classification of diseases, Western science, and traditional knowledge. A portion of that contemplative inquiry made it into written form; a selection thereof is presented in the scholarly paper intended for publication.

McLuhan and McLuhan's (1988) work also inspired me to follow a linguistic tangent about differences between Indo-European languages and Inuktitut. For an English-speaking nurse, the two words 'no' and 'show' are abstract representations detached from an object. On the other hand, an Inuktitut speaking client understands language in a succession of basic meaning units that express reality and human experience. I started to comprehend that calling somebody a 'no-show' seems rather insignificant for a Westerner; its use and its theoretical implications could be easily shrugged off as something not that serious. However, such an abstraction carries the meaning of a reality full of negativity and judgment of performance if understood by an Inuk because of the "audile-tactile orchestration of the senses" (McLuhan & McLuhan, p.

33) in the Inuit use of language. Inuktitut consists of words that are not abstractions. They look like “a series of commentaries on the characteristic features perceived by Inuit speakers as relevant for describing the contemporary world” (Dorais, 1990, p. 249). This linguistic tension by itself would be worthwhile to be explored as one way in which cross-cultural practice shapes the experience and outcome of health for Inuit. I set the parameters of this practice project too narrow to have sufficient space to include all of the interesting aspects of interconnected realities of the practice of using the “NO SHOW” stamp. I hope I have chosen appropriate ones to make a good argument in the case.

Purpose of the Practice Project

The purpose of this project is to initiate a discussion about the use of the “NO SHOW” stamp, a taken-for-granted practice - backed by an unwritten policy - which I have observed while practicing as a nurse in several primary health care settings in Canada’s North. Besides the informal and formal discussions about the issue I had in the work place, I would like to share my awareness of the issue with a wider audience. I have briefly elaborated on the need and reasoning in the background section above. The next part of this project is a scholarly article intended for publication about the practice of using the “NO SHOW” stamp and its effects. The intended audiences for the article are policy advisors in the health field (in government and in health care organizations), academics (nurse educators and health researchers), and students and continuing learners in the health services field. The article is not yet formatted or edited for a particular journal in order to meet the university’s formatting requirements for this paper.

For the third part of this project, I have created a policy briefing note for decision makers in Nunavut on the use of the “NO SHOW” stamp in their primary health care

settings (Appendix A). In this way, I will be able to address directly the people with the political power to initiate and implement change. A briefing note is a condensed paper used in a political decision making process (Young & Quinn, n.d.). An advisor who is familiar with and has thorough knowledge of the subject matter prepares it for a decision maker without specialized background and knowledge of the particular issue. The attached briefing note is suitable for distribution to the Executive Directors within the Government of Nunavut, Department of Health and Social Services. As an operational policy issue, it does not have to be written as a cabinet submission that will be decided at the Minister's level. Executive Directors in the Government of Nunavut structure are the heads of the three regional divisions of the Health and Social Services Department. The directors or managers of various health services programs and facilities take direction and report directly to the Executive Directors. Operational policy is crafted, implemented, evaluated, and overseen at the level of directors and managers. The attached briefing note can also serve as a template for use in other jurisdictions. The contents of the briefing note need to be adapted to reflect the jurisdiction-specific details of political platforms and organizational structures and cultures.

Project Objectives

As an advanced practice nurse, in my attempt to practice safely across cultural diversity, I want to contribute to improving an aspect of nursing practice in Primary Health Care that I recognize to be unhelpful. Through this project, I investigate the use of a particular tool, but I also touch on nurses' attitudes because they are inseparable from the cultural practice. Both of them I have personally witnessed during my recent employment in the Kitikmeot Health Centre in Cambridge Bay, Nunavut. I will conclude

the article with two recommendations: one at the operational policy level for the use of the tool, the other one on a more abstract level. The latter will sound more like an appeal to individual nurses to reflect on their attitudes and actions, and to nurse educators and curriculum developers to provide future nurses with the skills and knowledge to do so. Changes at the individual level are essential in building peace in health care delivery and will contribute to health and healing of population groups above and beyond providing care to an individual in a disease-specific case. I have integrated anecdotal evidence, personal observations, published research, and theory from several disciplines to draw from a variety of information sources for a systematic exploration of the use of the “NO SHOW” stamp.

I have chosen a case study approach to what I consider a cultural practice⁵ as the basis for the article. I applied the Laws of Media framework by Marshall McLuhan as the most appropriate one to tease out the subtle effects of the phenomenon of concern. Culture is a range of knowledge and learned human behaviour patterns; therefore any pattern can be unlearned and replaced if deemed no longer appropriate. The project

⁵ It is a basic assumption of mine that cross-cultural practice is an interaction between members of divergent cultures. Culture is not only ascribed to members of identifiable ethnic groups different from a self-declared ‘neutral’ reference point, usually located within a dominant, mainstream society (the same way as the human skin colour spectrum is defined as different from the ‘neutral’, white skin complexion). Every person can be a cultural being in multiple ways. Personally, I am Swiss, I am Canadian, but I am also a nursing professional. I am carrying and representing particular sets of values and beliefs from each of the groups I identify with. As a nurse, I have to be critically aware of the nursing culture and the institutional culture of my practice environment, as well as the contemporary, mainstream ‘culture of health’ to avoid hegemonic practices (Anderson & Reimer Kirkham, 1999). These authors define culture as a “complex, dynamic process grounded in everyday actions [that is] enmeshed in the social and economic processes and relations of power between dominant and ‘subordinate’ groups” (p. 48). It is therefore not a static, unchangeable set of rules and habits.

objective of improving an aspect of nursing practice is anchored in this understanding of culture. Looking at cultural patterns requires a different approach than looking at clinical problems: Rather than isolating a phenomenon for study and controlling variables, a wide range of contexts need to be considered concurrently (Saukko, 2005). Throughout the article, I use references to nursing concepts and knowledge in order to illustrate the links of this project to the nursing profession.

It is my hope to make a small contribution with this practice project to reducing health disparities and other forms of discrimination that continue to linger in the provision of health care services, particularly in Aboriginal communities in Canada. Furthermore, I also hope that the process of making such subtle forms of discrimination visible will be sufficiently generalizable and applicable in many other settings where people are being marginalized by taken-for-granted practices across cultural differences. I will be able to conceptualize future research projects at the intersection of health and peace on the insights gained from this theoretical inquiry.

ABSTRACT

The “NO SHOW” stamp in Primary Health Care: Making peace with a colonial legacy

Practicing in a cross-cultural environment requires nurses to be critically aware of their personal and professional cultural attitudes and behaviours. In this article, I analyze the practice of using a “NO SHOW” stamp in primary health care settings in Canada’s North. The aim is to examine the effects of this practice, which is embedded in nursing cultures in specific practice environments. Conclusions may contribute to highlighting health disparities encountered by Aboriginal populations. A case study approach using McLuhan’s Laws of Media is employed to examine this taken-for-granted tool, its use, and its implications. The analysis is structured using a tetrad of questions posed by McLuhan. The use of the stamp extends paternalism, obsolesces the individual story, signifies authority, and reverses caring. Social, political, and cultural aspects of colonial history and health culture are discussed. I use examples from personal observation to describe nurses’ attitudes about non-attendance of scheduled appointments. Based on this inquiry, it is recommended to discontinue the practice of using the “NO SHOW” stamp because of its discriminatory connotation. Such policy change will strengthen cultural safety in nursing practice and contribute to reducing health disparities.

Keywords: Cross-cultural practice, cultural safety, health disparities, racism, primary health care, Aboriginal health,

INTRODUCTION

Nursing practice in cross-cultural settings requires the same set of learned skills and clinical competencies as nurses do in any setting. However, working across cultural differences requires nurses to have additional cultural competencies (Anderson, L.M., Scrimshaw, S.C., Fullilove, M.T., Fielding, J.E., Normand, J. & Task Force on Community Preventive Services, 2003). Cultural competency, a set of behaviours, attitudes, and policies, can be challenging because it requires nurses to critically examine their own cultural behaviours and attitudes. It is important to understand how nurses shape their practice and how the same shapes nurses. The purpose of this paper is to initiate a discussion about a taken-for-granted practice – the use of a “NO SHOW” stamp - observed in primary health care settings in Canada’s North.

Modern health care was introduced to the indigenous peoples in northern Canada through the process of colonization. Since then, the Aboriginal peoples have been renegotiating the relationships between themselves and the colonial forces as well as their definitions of health (Atleo, 1997). An examination of practices within nursing culture for their effects on health and healing of Aboriginal peoples through a postcolonial lens is a contribution to creating a critical consciousness toward a common vision of health. At the same time, eliminating colonial legacies with discriminatory connotations will help reduce existing conflicts. The following analysis of the practice of using the “NO SHOW” stamp will expose connections to covert racism and offer suggestions for improvement to cross-cultural practice and the reduction of health disparities.

Health disparities

Health disparities are systematic and avoidable forms of discrimination that provide a measure of social justice (Braveman, 2006). Other definitions of health disparities, less informed by the discourses of social justice and human rights, focus more on health status as defined by clinical and epidemiological factors or on the access to services. The Health Disparities Task Group (2004) distinguishes between health disparities, inequalities, and inequities. Their definition of disparity is based on differences in health status among population groups; inequality is defined as variation in achievements and risk factors based on genetics, personal choices, and social and economic organization, which includes access to services. Inequity then is defined as a category that allows statements on fairness and justice. It depends on normative judgment and extends beyond the realm of science. For this article, I rely on Braveman's definition of health disparities because of its integrated nature. It facilitates a qualitative analysis without the safeguards and limitations of a narrower categorization.

Braveman's (2006) definition mirrors the approach underlying the assessment of the relationship between Aboriginal and non-Aboriginal people in Canada by the Royal Commission on Aboriginal Peoples (1996). Health disparities among Aboriginal peoples and between Aboriginal peoples and the mainstream society in Canada are widely recognized. Since the publication of the *Report of the Royal Commission on Aboriginal Peoples* (Royal Commission on Aboriginal Peoples), health disparities could no longer be ignored, brushed aside as isolated incidents of unfortunate circumstances, or declared as consequences of deficient individual health behaviours. The report proclaimed "the health status of Aboriginal people in Canada today [a]s both a tragedy and a crisis"

(Royal Commission on Aboriginal Peoples, n.p.). Consistent with its holistic focus, the Royal Commission did not isolate the dismal health status of many Aboriginal peoples from the lack of self-governance, the unequal economic opportunities, the social and cultural effects of centuries' old subjugation and assimilation policies and practices. The report led to a significant restructuring of Health Canada, the department responsible for providing health care services to Aboriginal peoples (Health Canada, 2007).⁶

The scientific community has since increasingly embraced Aboriginal health as a noteworthy topic. The availability of government funding to address health disparities has led to the establishment of research centres and programs (see: Institute of Aboriginal Peoples' Health website). On the other side, health disparities are also newsworthy. The media uses them by sensationalizing particular aspects of Aboriginal health (see: Sweet, 2009). For example, in a recent news release in a medical journal on the spread of the influenza A (H1N1) virus, Kondro (2009) emphasizes remote Aboriginal communities as the location of the first pandemic outbreak. Aboriginality is the only descriptor used as the explanation for the location of the outbreak. However, the author seems to be implying unspecified risk factors based on widely known health disparities underlying

⁶ "Health disparities are recognized as a key health issue in Canada by all jurisdictions. Health ministries at all levels, often in collaboration with other sectors, have launched initiatives to improve health and reduce health disparities. Most of the identified initiatives focus explicitly on improving overall population health status; disparities reduction is generally addressed through a focus on specific populations or communities. In most cases goals or targets for improving the health of disadvantaged populations and reducing health disparities have not been set. There are few comprehensive, integrated efforts to address known health disparities and the factors and conditions that lead to them. This has resulted in promising, but often disconnected, initiatives across the country." (Health Disparities Task Group, 2004, p.16)

the term Aboriginal⁷. The author concludes the article with concerns about the timing and overall availability of a vaccine and about ways of distributing an antiviral medication. Disparities are portrayed as clinical problems that can be solved with the right treatment or increased funding; hence, news stories frequently identify the need for additional programs and services or changes in legislation and regulations.

Living in and working with Inuit, First Nations, and Métis communities can provide a unique perspective on the health status of and the causes of disparities among Aboriginal peoples. Over the years, I have made many personal observations, but none stand out as much as the lively discourses among health professionals about clients' compliance and the honoring of appointments. Nursing colleagues and professionals from other disciplines seem to be convinced that increased compliance with prescribed treatments and improved attendance of medical appointments will significantly reduce the rates of reported and perceived ill health in Aboriginal communities. This attitude is rooted in the health belief model that emphasizes individual responsibility for health that can be ultimately influenced by health information about risk and benefit (Young, 2002). Thus, they are implying irresponsible behaviours as a cause of ill health and health

⁷ A related online news article reports that there is no indication of a higher incidence of the influenza A (H1N1) virus in the Aboriginal communities compared to the mainstream settlements within the same geographical region (Canadian Broadcasting Corporation, 2009, September 18). However, the same news source featured in an earlier article the disproportionate prevalence and incidence of influenza A (H1N1) in certain Aboriginal communities – citing substandard living conditions and preexisting disease as potential explanations (Canadian Broadcasting Corporation, 2009, July 20). Such news articles are contributing to a public perception of health disparities that is implied in the Canadian Medical Association Journal article (Kondro, 2009). By specifying preventable causes for the existing disparities, the news also stirs an underlying notion of self-inflicted harm and irresponsible behaviour. However, they fail to address the issues at the level modeled by the Royal Commission on Aboriginal Peoples (1996).

disparities. I have witnessed comments from nurses who have summarized said notion of irresponsibility openly with words like “those people are not able or willing to take care of themselves”⁸, effectively blaming the victim for the occurrence of ill health and health disparities. The onus for missing appointments and the perceived health consequences thereof is put exclusively on the client. Browne and Fiske (2001) state that the mechanism of victim blaming is one of the legacies of colonial ideology informing the federally sponsored health services for Aboriginal communities. The witnessed remarks seem to be acceptable as an uncontested sentiment within a health care culture that informs the practice of nurses in the health centres.

Non-attendance as a source of ill health?

Despite this commonly held view, non-attendance is mainly studied as an economic concern for health care providers. Innovative solutions are sought to improve operational efficiencies and to minimize financial losses (George & Rubin, 2003). Health outcomes related to attendance are rarely investigated. One systematic review looked at the effectiveness of primary health care services and specialist outreach clinics for rural, remote, and disadvantaged populations (Gruen, Weeramanthri, Knight, & Bailie, 2009).

⁸ The Health Disparities Task Group (2004) describes in the following quote a similar notion for Canadians with a lower socio-economic status (SES), which includes an above average percentage of Aboriginal people: “The origins of poor health are not just money, although money and the decision latitude it affords is a factor. Low SES often translates into low self-esteem, the absence of life skills essential to making healthy choices, an unhealthy physical environment, indifference to risky behaviours, the stress of working in low wage, precarious employment and a lack of opportunity to participate in community life, etc.” (Health Disparities Task Group, p. 3). Although these words are less harsh than some of the statements I witnessed, they include the elements of ‘inability’ (absence of life skills) and ‘unwillingness’ (indifference to risky behaviours).

It indicates that the availability of such services alone will improve attendance but not impact the health outcomes of the populations. The authors argue that it takes more complex multifaceted interventions and a collaboration of services in order to achieve improved outcomes for disadvantaged communities. None of the reviewed studies have explicitly controlled the influence of cultural factors, such as culturally appropriate care (Anderson, Scrimshaw, et al., 2003) or cultural safety (Ramsden, 2002), when analyzing attendance and health outcomes. I have postulated elsewhere that differences in worldviews between the medical and diverse Aboriginal cultures require from the health care providers an ability to operate in more than one paradigm in order to bridge the apparent gap and to avoid ineffectiveness and misunderstandings (Arnold & Bruce, 2005). I can only suspect that differences in worldviews can produce competing priorities and influence the attendance rates for scheduled medical appointments. Martin, Perfect, and Mantle (2005) quote a general practitioner's observation that "what's going on in their lives" (p. 640), experiences that have a higher priority for the clients than immediate medical care, lead to missed appointments. However, future research is needed to illuminate more specific links between diverse health beliefs, attendance, and health outcomes.

In my own practice, I have observed and experienced that direct and specific communications between the nurse and the clients about a plan of care and the necessary appointments have a high success rate, even with clients that have a record of repeatedly missing appointments. The established process of generic appointment reminders through

phone messages from clerical staff⁹ or hand-delivered written notes¹⁰ lacks proven effectiveness. Research from other primary care disciplines shows that improved communications strategies (Capko, 2009), – which in some populations could include text message reminders as one example (George and Rubin, 2003) - can reduce non-attendance rates. However, I have no evaluation that supports a hypothesis that the improved attendance rates for individual cases, based on direct nurse-client communication, correlate with better health outcomes or reduced disparities.

The “NO SHOW” stamp

One tool illustrates, documents, and perpetuates the core of the non-attendance discourse: The “NO SHOW” stamp used in health centres across Canada’s North. For the uninitiated, the tool is an office rubber stamp displaying the words ‘no’ and ‘show’ in capital letters. It is used in conjunction with a red ink pad to record missed medical appointments. At the end of the clinic day, a clerk or a nurse uses the “NO SHOW” stamp to make an entry into the personal health record of a person who did not attend a

⁹ I often received feedback from clients that they were not made aware why they have to come to the clinic. Some clients also deny that they have been called at all for some appointments. Clerical staff in the health centres is not aware or authorized to specify the rationale for scheduled appointments. Therefore, they can only inform or remind a client about upcoming appointment dates and times. Furthermore, it has not been evaluated whether a phone message is considered as being delivered if contact has been made with the specific client, or if it is satisfactory to the clerical staff to have contacted any member of a household or even an automated answering system at the number called. However, these factors could significantly influence the effectiveness of the appointment and reminder system.

¹⁰ Households without a phone line will be served by hand-delivered notes. These notes are written in English. In many communities in the North literacy rates and skills are limited. This is compounded by the fact that many older people are speakers of their Aboriginal languages and have no or very limited knowledge of the English language.

scheduled appointment. In addition to the stamp, the date and the initials of the person making the entry are recorded. This is in lieu of the nurse or doctor's note that would have been entered for the scheduled visit. The use of paper charts as the permanent health records in health centres continues to date. All the progress notes are made by the attending health professional with blue or black pen in handwriting.

In this article, I will examine the "NO SHOW" stamp as a tool and the implications of its use in the provision of health care services to Aboriginal communities particularly in Canada's North. My analysis is informed by Marshall McLuhan's critique of development of technology: he postulates that humans shape their tools and in return become shaped by the same (McLuhan & McLuhan, 1988). Technologies, in this sense, are ways of encoding reality. They become media carrying messages of how the world is organized. How individuals encode the world affects cultural forms, societal structures, and the way knowledge is internalized. Indeed, McLuhan understood media as working like language, with internal structures and rules, or grammars. Examining the grammatical structures of the practice of using the "NO SHOW" stamp requires a deeply historical approach, since they evolve from cultural, social, political, and economic contexts.

HOW TO EXAMINE THE TAKEN-FOR-GRANTED?

This theoretical inquiry is primarily grounded in my own lived experience as a community member and as a member of various health care services in Canada's North. It is guided by the central question how to identify factors beyond the immediate medical and epidemiologic causes that may contribute to the significant health disparities

encountered by Aboriginal populations in comparison to the general population in Canada. The second question is: How do taken-for-granted ways health care professionals practice in a cross-cultural context with Aboriginal communities shape the experience and outcome of health?

I have observed the use of the “NO SHOW” stamp in the Yukon and in Nunavut. The use of the tool is part of the institutional culture in health centres and nursing stations across the North. It does not cause more than an imprint in a patient’s chart and it has no seemingly direct effect on patient outcomes or population health. However, the cumulative observations of the stamp’s use and my own reflections on its effects relating to the provision of culturally safe¹¹ care registered with me. It caused sufficient moral distress (Storch, Rodney, Pauly, Brown, & Starzomski, 2002) that I started to question the practice as part of the nursing routine in a primary health care setting.

For uncovering the context of the particular practice of using the “NO SHOW” stamp, I employ McLuhan’s *Laws of Media: The new science* (McLuhan & McLuhan, 1988). This framework is suitable for the purpose of this analysis because it was conceptualized by McLuhan to study the effects of technology. It is a platform for an interdisciplinary and critical analysis with a historical perspective. I will stop short of a description of the structure of health care delivery to Aboriginal peoples in Canada, its

¹¹ Culturally safe refers particularly to the work of Ramsden (2002). The concept of cultural safety is addressing power relationships between nurses embodying dominant Western culture and science, and clients with a colonized indigenous history in New Zealand. Cultural safety aims at identifying attitudes that exist in health care and tracing them to their origins. It also wants to show their effects on practice. Research by Anderson, Perry, Blue, Browne, Henderson, Khan, et al. (2003) expands the concept in the Canadian context to avoid the pitfalls of essentializing racialized categories in a multicultural society. These authors argue that the concept of cultural safety holds promise for transformative practice to reduce conflict in health care delivery.

complicated historical context, the health status over time (see Waldram, Herring, & Young, 1995), and the epidemiology of the health disparities. McLuhan's framework is applied to the tangible tool; however the discussion of its effects extends to its use as well its users. I include observations and anecdotal evidence from both the practitioner and client's side and link them with published research findings. The discussion is grouped under three war theme headings to emphasize the hidden conflicts. Based on the perceived dilemmas attached to the taken-for-granted practice I will formulate recommendations toward a peaceful solution.

McLuhan's Laws of Media

McLuhan postulates that every technology¹² will (1) extend some human trait or experience, (2) render obsolete an established way of doing things, (3) retrieve a long-lost method or experience, and (4) reverse into its opposite if pushed far enough (McLuhan & McLuhan, 1988). McLuhan's framework is designed and tested to make explicit content and message of a wide range of media¹³. The above tetrad of statements was the end

¹² In nursing, the term technology is commonly used in connection with highly complex instrumentation for diagnosis and treatment and the computerization of information and communications processes. McLuhan's use of the term is much broader and more in line with the Declaration of Alma Ata (World Health Organization, 1978), in which the principles of Primary Health Care were defined. There, technology is described in context of practicality, soundness, and social acceptability for specific cultural and socioeconomic circumstances. It can include everything from medical terminology, documentation standards, to high-tech gadgets. The "NO SHOW" stamp embodies two aspects of technology: It is both a tool (for simplifying record keeping) and a communications code (for standardizing charting entries).

¹³ The direct, verbal message of the "NO SHOW" stamp is an abbreviated version of: This person did not show up to attend and did not cancel a scheduled appointment. The other message it produces is visual one: The stamp stands out like a sign or a symbol in a

result of a single research question: “What general, verifiable (that is, testable) statements can be made about all media?” (McLuhan & McLuhan, p. 7). Because of its heuristic nature, McLuhan’s proposed procedure can be applied and tested by anyone. To maintain its universality, McLuhan does not propose an underlying theory or paradigm.

McLuhan’s approach to uncover deeper meanings in media and what he calls ‘human artefacts’¹⁴ assumes that the figure – in this case the actual rubber stamp – cannot be separated from its ground¹⁵ – the environment in which it operates (McLuhan & McLuhan, 1988) – in this case the nursing practice in the North. The technology works through its context. For McLuhan it was important to understand that:

[p]revious technologies have affected the social, political, economic, and cultural aspects of society, as well as the individual members of society.

The present environment, itself made up of the effects of previous

personal health record among all the handwritten entries. The visual message draws much more attention than the message the two words convey.

¹⁴ “All of man’s artefacts [sic] – whether language, or laws, or ideas and hypotheses, or tools, or clothing, or computers – are extensions of the physical human body or the mind” (McLuhan & McLuhan, 1988, p. 93). In this sense, the “NO SHOW” stamp is an extension of the human body (the hand used for writing) and the mind (through the different effects shown in the analysis and discussion below).

¹⁵ Figure and ground: “...the ground of any technology is both the situation that gives rise to it as well as the whole environment (medium) of services and disservices that the technology brings with it.” (McLuhan & McLuhan, 1988, p. 5). As I will discuss later, the “NO SHOW” stamp originated somewhere in the bureaucracy of the colonial authority in Canada, the Department of Indian Affairs and Northern Development, and its field services. Therefore, the ground for the tool consists of a historical continuum from the European exploration of North America to the colonial promise of the medicine chest in Treaty No. 6 (1876) to the present-day health care systems that are increasingly controlled by local and Aboriginal political entities. According to McLuhan’s assertions, the tool cannot be isolated from that background to uncover its meaning.

technologies, gives rise to new technologies, which, in their turn, further affect society and individuals. (Gabriele & Stober, 2007, n.p.)

The following analysis will examine how the tool is interconnected to the rise of ancient civilizations, how developments in Canadian society affect the usage of the stamp, how using the stamp affects nursing practice, and the effects it has on clients.

THE USE OF THE “NO SHOW” STAMP

The practice of using the “NO SHOW” stamp is directly linked to attendance rates for medical appointments. The rate of non-attendance for scheduled appointments in the primary health care system in Canada’s North or for Aboriginal communities has never been compiled in a scholarly manner. For the Kitikmeot Health Centre in Cambridge Bay, Nunavut, the rate is 35% (Jean Conrad, personal communication, March 2009). George and Rubin (2003) report non-attendance rates in primary care between 5 and 55%. In the literature, particular problem areas for the phenomenon of above-average non-attendance rates for medical appointments are identified. For example, Izard (2005) emphasizes the “urban populations in underserved communities” (p. 65). Izard states that the national average in the United States for non-attendance in family practice is 5.5%. Over a two-year observation period, his praxis group catering to a diverse population experienced a non-attendance rate of 30%. By associating the severity of the non-attendance issue with underserved communities, Izard implies that racialization and poverty seem to correlate with above-average non-attendance rates.

The health centres in Canada’s North collect attendance data. One of the methods uses the “NO SHOW” stamp. For this article, I am not concerned about the actual rates.

The focus is on the implications of the tool’s use in providing Primary Health Care services to Aboriginal peoples. Table 1 shows the tetrad of media effects for the “NO SHOW” stamp based on McLuhan’s framework. I will explain the four statements in more detail below.

<p>What does the medium/technology extend?</p> <p>Paternalism</p>		<p>What does the medium/technology reverse if pushed too far?</p> <p>Caring</p>
	<p>“NO SHOW” stamp in Primary Health Care</p>	
<p>What does the medium/technology retrieve that was made obsolete earlier?</p> <p>Seal</p>		<p>What does the medium/technology make obsolete?</p> <p>Individual story</p>

Table 1: Tetrad of media effects for the “NO SHOW stamp in Primary Health Care.

What the technology extends: Paternalism

A parent standing over a child is the mental image that the no-show message produces in me. He is scolding or lecturing the child about not showing up on time. Paternalism is a human experience accepted as normative in family units and some societies (Dworkin, 2009). The motive for paternalism is to prevent harm or to produce

good for the other person. It occurs when a person ignores the stated or presumed wish of another human being (Miller, 2003). In child rearing, a paternalistic attitude is rarely questioned. However, in a health care context, a variety of legal and ethical concepts need to be considered. Miller provides a broad discussion thereof, focusing on questions of autonomy and beneficence, but also including responsibility, competence, freedom, agency, and equality. I will discuss paternalism below in a colonial context, where autonomy, competence, and agency are denied and where rhetoric of responsibility is used as a cover for subjugation.

Use of the “NO SHOW” stamp extends paternalism in the following way: It marks the record of a scheduled but non-attended medical appointment, which needs to be for the benefit of or to prevent harm to the client. At least, it has to be benevolent. A client may initially have agreed or consented to such an appointment, but subsequently decided that it is no longer necessary or feasible to attend. The entry into the client’s personal health record is an act against the client’s wish not to attend. It is difficult to imply consent in the absence of a nurse-client interaction (Brennan, 1997).

Dworkin (2009) suggests three conditions that need to be met to distinguish paternalism from other forms of disagreement or refusal to cooperate:

- (1) Z (or its omission) interferes with the liberty or autonomy of Y.
- (2) X does so without the consent of Y.
- (3) X does so just because Z will improve the welfare of Y (where this includes preventing his welfare from diminishing), or in some way promote the interests, values, or good of Y.

(Dworkin, p. 3)

Use of the “NO SHOW” stamp interferes with the client’s decision not to attend a scheduled meeting by creating a negative record. This is done without the client’s consent. However, the scheduled meeting was supposedly intended for the benefit of the client’s health.

Use of the “NO SHOW” stamp also extends paternalism in the undertone of the message. It implies bad performance, increased risk, and liability for health consequences. Many clinicians consider non-attendance of medically necessary appointments as irrational behaviour (Buetow, 2007). I have rejected several other options for traits or experiences that are extended or enhanced by the tool. Efficiency is one of them. Using the “NO SHOW” stamp is an efficient way for making repeat chart entries for frequent occurrences. However, it is the only stamp used for charting purposes in personal health records. Its significance, therefore, must be rooted in a trait or experience other than efficiency. There are numerous clinical encounters whose recording could equally be done more efficiently using a specific stamp versus a handwritten entry.

What the technology makes obsolete: Individual story

A chart entry using the “NO SHOW” stamp is very succinct. Insofar, the tool meets the third principle¹⁶ of the nursing practice standard for documentation established by the College of Registered Nurses in British Columbia (2008). The stamp is

¹⁶ “3. Nurses document all relevant information about clients in chronological order on the client’s health record. Documentation is clear, concise, factual, objective, timely and legible. Nurses clearly mark any “late entries,” recording both the date and time of the late entry and of the actual event.” (College of Registered Nurses in British Columbia, 2008, p.1).

standardized and records only the need to know facts: The person did not attend a scheduled appointment. It meets the nursing documentation standards insofar as it communicates the nurse's observation. On the other hand, the use of the stamp renders the individual story and the context obsolete. There is no need to further investigate how the scheduled appointment came to be, what its medical or nursing rationale was, how it was communicated between the health care provider and the client, what the client's needs, wishes, and circumstances could have been, or how the non-attendance unfolded. This can be seen as a significant loss of nursing knowledge about the client. Lacy, Paulman, Reuter, and Lovejoy (2004) show that making and keeping appointments is a complex interaction between booking systems, symptoms, emotions, anticipated consequences, and the quality of relationship with the clinician. Using a standardized message to record non-attendance excludes the individual story of the event as a source of knowledge for the nurses.

What the technology retrieves: Seal

The office stamp is a derivative of the ancient stamp seal. A seal is used to indicate the authenticity and validity of an official document and is always associated with identity, authority and responsibility (Platt, 2006a). The 'seal of approval' is used as a certification mark by an institution that claims to be authoritative. Platt summarizes "the seal's philosophical appeal lay ultimately more in its social significance – as a guarantor of authenticity and marker of the self – than in its true ontological status" (2006b, n.p.) Buetow (2007) discusses how non-attendance challenges the epistemological superiority of the health professional and how important it is to maintain the disproportionate influence health culture has on shaping societal norms. This is an aspect in connection

with the use of the “NO SHOW” stamp that I will discuss later: Making an impression with the tool may not primarily record a non-attended appointment; metaphorically speaking, it makes an impression of the nurse upon the world. What could make it appealing to nurses to assert their identity or authority with a seal-like tool? Nurses are part of the medical system whose dominance over health culture is hardly challenged in contemporary societies.

What the technology reverses if pushed too far: Caring

The concept of caring has at its core attributes like relationship, action, attitude, acceptance, and variability (Brilowski & Wendler, 2005). The authors identified the consequences of caring as increased health and healing as well as a sense of solidarity and empowerment for the client and the nurse. If the use of the “NO SHOW” stamp is pushed too far, caring is being reversed through labeling and stereotyping¹⁷. I have witnessed in practice how individuals and population groups were being deemed unreliable, careless, uncooperative, and incapable in the context of the no-show debate

¹⁷ Mullaly (2002) states that stereotypes may be positive or negative, but most of them are ultimately harmful. Stereotypes are the means of a dominant group to reinforce its privileges and position of power over a subordinate group. The mechanism of stereotyping is often insidious: People of a particular cultural group see themselves as representing humanity or as being the norm. They reinforce their point of view by contrasting it to the other and by assuming that one’s own position is right or superior. A hierarchy of values is being established by labeling the diverse experiences in a negative way (deviant or inferior). For example, clients as human beings instead of their actions are labeled as a *no-show*. Mullaly also states that stereotypes become internalized by members of the dominant group and thus are no longer critically questioned. Therefore, stereotypes may become part of an oppressive mechanism: The diverse group is constructed as problematic. Once the dominant group starts acting on solving the problem, racism occurs. Nurses who try to teach the notorious no-shows (people who repeatedly miss appointments as documented by the “NO SHOW” stamp) a lesson are discriminating against them.

among nurses. Martin et al. (2005) documented similar attitudes among general practitioners in the United Kingdom.

I relate the ‘pushing too far’ to the witnessed frequency and intensity of the no-show debate among nurses in health centres across Canada’s North. The theme of non-attendance of population groups often referred to as “them”, meaning the Other¹⁸ - most often specifically referring to Aboriginal populations – occupies a space in professional and informal meetings among health professionals that seems out of proportion in comparison to the enormous diversity of other potential discussion topics in the health field. During a two-week period in May 2008, 75% of the daily thirty-minute morning report in a health centre in Nunavut was used to elaborate on the no-show theme. Not all of the witnessed contributions were professional or scholarly. Buetow (2007) requests respect for differences in belief systems and rationality related to non-attendance and cautions about the marginalizing effects, the loss of dignity, and the escalation of conflict. He put the onus to care on the dominant group, in this case the nurses.

McLuhan suggested an alternate phrasing for the question of what a medium reverses: “What does it produce or become when pressed to an extreme?” (McLuhan & McLuhan, 1988, p. 7). Based on the witnessed contributions, the use of the stamp when

¹⁸ Reimer Kirkham (2003) provides a thorough description of the construction of the Other in cross-cultural practice. Her analysis speaks to the concepts of identity and belonging, as well as the politics of marginalization and inequities. The study supports my notion of persistent social constructions of ‘us versus them’ among nurses. They contradict the assumption of respectful and equitable care as the foundation for health care delivery in Canada and provide a significant potential for conflict. The ‘us versus them’ discourses relate back to the seal that provides a marker for a particular social identity.

pushed to an extreme suggests *racism*¹⁹. For this analysis, I find it more constructive and relevant to answer the question in the form “what does the technology reverse when pushed too far?”, which leads to the concept of caring. Relating the effects of the practice of using the “NO SHOW” stamp to the nursing concept of caring will illustrate better the delicate balance between the nurses’ contributions to health and healing and oppressive practices. Caring and racism are in opposition. Insofar, the two possible answers do not alter the overall dynamic of the tetrad since the direction of the two questions is opposite. I will address the issue of racism briefly in the next part of the paper. The above analysis, by making visible media effects of the “NO SHOW” stamp using McLuhan’s tetrad of questions, is for me the starting point for an exploration of the wider context of the practice through a discussion in the following part of the paper.

¹⁹ “Racism refers to institutional and individual practices that create and reinforce oppressive systems of race relations whereby people and institutions engaging in discrimination adversely restrict, by judgment and action, the lives of those against whom they discriminate.” (Krieger, 2003, p. 195)

DISCUSSION

The initial response from colleagues to the phenomenon of concern for this article was utter disbelief. In their worldview, there is nothing interesting or important to write about a rubber stamp. This holds true when the tool is viewed in isolation. Only if people see their being, their actions, and their tools as interconnected with history and the cultural, social, political, and economic contexts, the study of the “NO SHOW” stamp becomes relevant. The initial response from the nurses illustrates that the practice of using the “NO SHOW” stamp is taken for granted. It is therefore given no further consideration in the day-to-day clinic operations. The idea that the use of the tool could be interconnected to the health disparities described above does not easily surface in people’s mind.

“Indian Wars”: Colonial legacy

Paternalism as a corner stone of Aboriginal health policy in Canada has been described before (Waldram et al., 1995). Initially, the impetus for delivering health services to Aboriginal populations came from the dramatic effects of epidemics of infectious diseases like smallpox or tuberculosis. The rendering of assistance in time of need, as promised in Treaty No. 6 (1876), was subject to “the sympathy of the Queen” (Morris, 1880, as cited in Waldram et al., p. 176). Subsequently, bureaucrats and poets like Duncan Campbell Scott painted a picture of desperation, destitution, and incompetence among Aboriginal peoples, providing justification for paternalistic intervention (Brownlie, 2003). Advances in medical sciences and the development of a

comprehensive health care system in Canada's North have greatly reduced the incidence and prevalence of infectious disease outbreaks. However, health disparities have not disappeared. They have rather shifted to chronic non-communicable diseases and social pathologies (Waldram et al.).

As the focus of the primary health care services shifted from responding to dire emergencies to a range of acute care and public health services, including chronic disease management, the way clients engage with the system has changed accordingly. For acute services, the client initiates contact by booking an appointment or presenting to the clinic as a walk-in. Many acute conditions require follow-up appointments to evaluate the effectiveness of treatment based on practice guidelines for the nurses working in an expanded role. All the public health programs are by appointment. The nurses schedule the clients according to evidence-based guidelines and agency policy. It is part of the nurses' professional responsibility to meet those standards and to encourage compliance. From my observations, nurses schedule follow-up appointments without further consultation with the client. The appointment times are then relayed from the health centre to the clients by support staff. However, this can lead to conflicts with clients who wish to engage with the health care system on their own terms (Buetow, 2007). Studies on patients' perceptions on non-attendance support the notion that direct communication about purpose and timing of appointments between the clinician and the client increases attendance rates and reduces conflict (Lacy et al., 2004; Martin et al., 2005). Furthermore, I state elsewhere that divergent worldviews between nurses and clients in Aboriginal communities can lead to frustrations (Arnold & Bruce, 2005), which can translate into avoidance of clinical encounters and missed appointments.

There is no direct evidence, but strong indications suggest that the “NO SHOW” stamp is a hand-me-down from the colonial administration of Inuit and First Nations populations. The stance on Aboriginal peoples of Scott, deputy superintendant for the Department of Indian Affairs from 1913 – 1932, is part of the public record and Canadian literature. He laid the groundwork for a paternalistic policy approach towards Aboriginal peoples in Canada for decades to come (Brownlie, 2003). The responsibility of providing health services to First Nations and Inuit was transferred from the colonial administration of the Department of Indian Affairs to Health Canada in 1945, but it took Health Canada until 1962 to deliver direct services to Aboriginal communities through its Medical Services Branch (Health Canada, 2007). Many Aboriginal people remember those services as oppressive: “...political authority was enacted through health surveillance, policy, and practice at the community level” (Waldram et al., 1995, p. 261). Some of the older records or pieces of equipment in many of health centres have a strong resemblance to military stationary and equipment of WWII heritage.

Before the 1970’s, the health services coverage in many areas of Canada’s North, particularly for the Inuit in Nunavut was sporadic. Initially, traders and missionaries provided some medical services as a sideline to their other occupation and without any specialized knowledge and training. Then, physicians provided traveling clinics from patrol and research vessels. Sometimes, physicians were flown into a community to respond to a particular emergency or epidemic (Waldram et al., 1995). Only with the establishment of the outpost nursing stations and health centres in the various communities, nurses working in an expanded role started to provide more continuous and comprehensive health services. I doubt that the “NO SHOW” stamp was systematically

used or justifiable before the establishment of the permanent health centres. There were no grounds for an appointment system with the sporadic and often unpredictable provision of service. However, in general, the attendance record of remote and disadvantaged populations for referred services to centralized care and treatment centres is marginal and continues to be lower than in the presence of outreach services (Gruen et al., 2009). In order to increase efficiency and to counteract what have been considered as notorious no-shows, Aboriginal people have been forcefully removed from their communities for medical treatment by the authorities. Some of these military-style round-ups during the anti-tuberculosis campaign traumatized the population and disrupted the functioning of up-to-then self-sufficient indigenous communities (Bjerregaard & Young, 1998). In many ways, the resemblance with the forceful removal of school children from First Nations reserves for attendance in residential schools by the colonial administration as part of the assimilation effort in Canada is striking. At the time, these genocidal actions²⁰ were justified based on epistemological superiority and for the overall well being of the Aboriginal peoples affected. The scientific and political establishments gave their seal of approval.

²⁰ UN Convention on the Prevention and Punishment of the Crime of Genocide, Article 2. In the present Convention, genocide means any of the following acts committed with intent to destroy, in whole or in part, a national, ethnical, racial or religious group, as such:

- (a) Killing members of the group;
 - (b) Causing serious bodily or mental harm to members of the group;
 - (c) Deliberately inflicting on the group conditions of life calculated to bring about its physical destruction in whole or in part;
 - (d) Imposing measures intended to prevent births within the group;
 - (e) Forcibly transferring children of the group to another group. (United Nations, 1948)
- Krebs (2008) deliberates in his opinion on the impact of the Government of Canada apology for the residential school system on particular links between the government's colonization of Aboriginal peoples and genocide as defined in international law.

“Civil War”: Professional power struggles

Only a few of the nurses working in the health centres in Canada’s North today remember the less civilized days of providing medical services to Aboriginal peoples. The “NO SHOW” stamp is thus isolated from the individual or collective memory of such events and practices. Therefore, it is not surprising to encounter an attitude of disbelief during discussions about the utility and implications of the tool. Why then would nurses maintain the use of the stamp for their daily practice so religiously?

One explanation could be sought in the struggle of the nursing profession to earn its autonomy and recognition from the medical profession²¹. Particularly in the outpost setting, nurses work in an expanded role and often perform the functions of a general practitioner. Daiski (2004) summarizes that historic struggle and illuminates it with recent evidence. The author discusses the inter- and intradisciplinary mechanisms and consequences of the perceived marginalization of nurses. The study does not address the question whether a continuum of hierarchies in the health care system can be extended to include the clients and patients. However, the author mentions that ‘oppressed group

²¹ Illich (1975) describes the medical profession as a corps of engineers that dominates all aspects of health in an industrialized world. The specialization of their technical expertise appears to justify their monopolistic power of definition of health and health care. Indeed, Illich (1975) argues, this one-sided attitude will create conflict among health professions, but also between the medical profession and the clients. Illich (2003) also expands on the idea that “[b]y transforming pain, illness, and death from a personal challenge into a technical problem, medical practice expropriates the potential of people to deal with their human condition in an autonomous way and becomes the source of a new kind of un-health” (p. 919). This constitutes yet another level of colonization (and not only of Aboriginal peoples) that I have not covered in this article.

behaviour' include "lashing out against ... those of lesser status" (Daiski, p.44), which can be constructed as including clients from the point of view of nurses.

The use of the "NO SHOW" stamp could well serve in the function of lashing out against somebody of lesser status, particularly in a system with paternalistic tendencies and traditions. As such, a stamped "NO SHOW" entry in a personal health record would be not far from a seal's impression on the world to mark the nurses' identity and status in the hierarchy of professions and disciplines in the health care field. Furthermore, it may be one form of expressing the assertion of power over the clients.

An alternate explanation could be sought in current workplace issues for nurses, from constant staffing shortages to mandatory overtime to provide around-the-clock coverage in remote Primary Health Care settings. These and other factors that reduce job satisfaction identified by Andrews, Stewart, Pitblado, Morgan, D'Arcy, and Forbes (2005) may lead to the same 'lashing out' response among nurses. A study about lateral violence among nurses documents similar triggers and responses along a power gradient (Johnson, 2009). Insofar, this review of lateral violence lends support to the above explanations for the nurses' affinity for the practice of using the "NO SHOW" stamp, because it postulates lateral violence as a complex interaction of social, individual, and organizational factors.

Liability is the main argument in defense of the use of the "NO SHOW" stamp that nurses have brought forward in discussion. They argue that in today's practice climate, the nurses have to reduce the risk from litigation. The nurses state that no-show entries are an indicator for continuity of care. It is sometimes the only recorded evidence of planned follow-up care. Therefore, it is important for them to record the non-attended

medical appointments in the personal health record equal to the progress notes for nurse-client interactions. However, the widespread fear of litigation among nurses is hardly supported by available data. Only 1.6% of legal cases against medical practitioners in Canada involve nurses (Worster, Sardo, Thrasher, Fernandes, & Chemeris, 2005). About 1000 cases are reported each year, a fraction of them go to trial, and 82% have favorable outcomes for the medical practitioner (Canadian Health Services Research Foundation, 2006).

Interestingly, efficiency is not mentioned in the discussions with nurses and staff as an argument for the use of the stamp. From a theoretical perspective, efficiency could be one theme that would need further consideration since the stamp as a technology clearly embodies elements of efficiency. However, looking into the future, the advent of electronic health records may alter the discussion around efficiency in keeping health records considerably.

The validity of a stamped no-show entry in a personal health record as appropriate documentation remains debatable according to professional documentation standards in nursing practice. The widespread use in primary health care in Canada's North indicates that such an assertion has not been challenged. Through documentation, as described in the practice support document by the College of Registered Nurses in British Columbia (2007), "nurses communicate their observations, decisions, actions and outcomes of these actions" (p. 5). The subsequent qualifiers for what nursing documentation describes are based on actions taken by the nurse, not on omissions by the client. The context-free message of the "NO SHOW" stamp might not meet those criteria for a nurse-client interaction to qualify for a charting entry. If risk management is the main rationale for a

no-show entry, an incident report would be the more appropriate form for such observation.

“Proxy Wars”: Challenging nurse-client relationships

In theory, nurses and clients are equal partners in decision making for an individual’s health care (Canadian Nurses Association, 2005). However, clients who are confronted with their non-attendance counterclaim that they frequently have to wait for considerable amounts of time when they are punctual for a scheduled appointment. There is no equivalent way of recording or even reporting such occurrences²² and the provider generally excuses the incidents with operational reasons. From my observations in practice, nurses’ time management can lead to delays in service for clients who present for their appointments on time. Capko (2005) emphasizes the importance for care providers to reciprocate the honoring of appointment times to reduce conflict and increase efficiency. Lacy et al. (2004) conclude from client interviews that mutual respect underlies the association of waiting, satisfaction, and non-attendance.

Oudshoorn, Ward-Griffin, and McWilliam (2007) have studied the sources of power in the nurse-client relationship and the exercise thereof. The authors describe ‘managing the clients’ as one of the mechanisms of power nurses use. “This ‘managing’ of clients often include[s] little negotiation with the client themselves. Examples of ‘managing’ clients without their input include[s] shifting the client to another nurse or moving them to another time slot” (Oudshoorn et al., p. 1439). This is a dominating

²² Since September 2009, the Nunavut Department of Health and Social Services made a generic brochure about patient/client complaints procedures available to the general public at the health centres.

practice driven by professional or systemic considerations with disrespect for relational and contextual aspects. The scheduling of appointments in the primary health care setting has similar qualities. The lack of consideration of the client's context and the insistence on professional needs (efficiency, proper procedure, risk management) appears to be a major source of conflict in the discussion about honoring scheduled appointments. On the other hand, the nurse can employ the positional power in positive, liberating ways for the benefit of the client, particularly in buffering between the technologically driven medical system and the client's needs for a humane experience of health and illness.

Browne and Fiske (2001) conclude in a study of First Nations women's experiences with the health care system that a variety of "invalidating encounters make evident [how] the routines of mainstream health care delivery, in myriad ways, mirror daily social encounters that marginalize First Nations women" (p.143). However, the narratives of affirming encounters in the same study "represent unexpected exceptions to the ubiquitous forms of racism and discrimination that shape women's everyday social experiences" (Browne & Fiske, p. 143). The key elements of the affirming encounters are respect, trust, non-discrimination, and shared decision-making. Negative stereotyping and unilateral labeling of the patient, such as a 'no show', and the disrespect for personal circumstances are important dimensions of the women's invalidating experiences.

Overall, the study of affirming and invalidating encounters by Browne and Fiske (2001) underscores the importance of examining carefully taken-for-granted practices in delivering health care in Aboriginal communities from a cultural safety perspective: A stamp on the desk of a nurse might not be as harmless as it appears at first sight.

“Striving for Peace”

Ramsden (2002) describes the power of attitude in cross-cultural nursing practice from a Maori perspective, which is based on many commonalities of the colonial situation endured by Canada’s Aboriginal peoples. She concludes from lived experience examples:

- (1) That it is very possible to create active barriers to service without recourse to spoken words.
- (2) That there are other discourses which are unarticulated and unanalysed but inform the behaviour of patient and professional.
- (3) That the influence of attitude can be a powerful inhibitor, or initiator of professional interaction.
- (4) That it is the responsibility of the nurse as the power holder to create an environment which enables people to feel safe in the presence of the nurse.
- (5) That unfavourable attitudes are easily recognised by those who have been exposed to their negative effects.
- (6) That those who have experienced the power of attitude imposition are always vigilant to the possibility of its presence. (Ramsden, p. 62)

The witnessed preoccupation with the no-show discourse by some nurses is an example of an attitude that can create barriers without a spoken word. Imagine a nurse who opens a personal health record that is stamped four or five times on the most recent page of progress notes with the red-inked “NO SHOW” stamp: Is it possible that such a visual display may influence the attitude of the nurse towards the client? Will it be possible for the provider not to think of the client as a problem in the context of working together as equal partners in decision-making? Will it lead to a prejudgment of the client in terms of reliability, cooperation, initiative, agency, and many more attributes that are

intrinsically linked to the paternalistic justification of colonial rule over and treatment of Aboriginal peoples in Canada in the first place? There will only be personal answers to these questions; no testable hypothesis will ever prove a causal link or correlation between the use of the “NO SHOW” stamp and any particular health indicator.

Nevertheless, visually singling out a group of people based on a generalized characteristic is the first step towards discriminatory behaviour and racism. Insofar, the use of the “NO SHOW” stamp shapes the lives of nurses as well as those of clients.

In summary, I would like to pull the discussion together into a blunt question: Does racism harm health? It is easy to dismiss racism in the absence of spectacular incidents against a particular racialized group. I started with the findings by the Royal Commission on Aboriginal Peoples (1996) that significant health disparities exist. Cultural factors embodied in professional practice, such as policies and the underlying attitudes based on the superiority of one particular worldview, are contributing to the oppressive mechanisms required to pursue domination and assimilation of Aboriginal peoples. Therefore, if nurses acknowledge that oppressive practices are part of racism and that such practices lead to health disparities for the subordinate population, then it ought to be accepted that racism harms health. According to Krieger (2003), being explicit about racism is a scientific necessity. Otherwise, all efforts to overcome health disparities will be in vain. Health disparities are not primarily medical issues and can therefore not solely be addressed by medically focused health research and epidemiology. Braveman (2006) clarified that health disparities cannot be separated from inequality, discrimination, and privilege, as well as the policies and practices that sustain them. I have argued that the use of the “NO SHOW” stamp in primary health care enhances

paternalism, signifies authority, makes the individual narrative obsolete, and threatens caring. Discrimination, a behaviour based on prejudice, is grounded in similar elements: Superiority, power, generalization, and separation (Quillian, 2006). Hence, it is difficult to eliminate a discriminatory connotation and racist potential from the use of the “NO SHOW” stamp.

Caring includes building strong relationships across cultural differences, reflecting on attitudes and actions from a cultural safety perspective, and accepting that questionable practices need to be changed as new insight is revealed. As a small gesture towards reducing health disparities of Aboriginal populations in Canada’s North, I recommend retiring the “NO SHOW” stamp. This step would consequentially enhance the cultural safety of daily practice. All the valuable points of using the tool can be addressed in alternate ways. In Nunavut, statistical information about service utilization is already being collected in the appointment management database: no-shows are recorded as such. The concerns about liability and reduction of the litigation risk need to be addressed in a more appropriate way: Nurses need to positively record an interaction with the client, for example as the phone call to invite the client for the six-month follow-up as per hypertension guidelines and the client’s response. If the client does not honor the appointment, a lack of corresponding entry will be the deductive documentation thereof. In case of litigation, an isolated, stamped no-show entry will be less convincing evidence of caring than a brief handwritten entry stating the action and the client’s response.

Examining and understanding the cultural, social, and historical dynamics of taken-for-granted practices is like doing a conflict analysis before there is an acute and

open crisis. It could be part of the foundation for lasting peace²³. A reduction of health disparities between the Aboriginal populations of Canada and the mainstream society will be a strong indicator for peace.

²³ Peace is more than the absence of war: It can be described as the absence of violence in all its forms - physical, social, psychological, and structural. Brock-Utne (1989) provides an elaborate analysis of peace as the absence of:

1. unorganized, personal, physical, and direct violence (i.e., domestic violence)
2. organized, personal, physical, and direct violence (i.e., war)
3. unorganized, indirect violence which decreases the life span (i.e., poverty)
4. organized, indirect violence which decreases life span (i.e., cancer caused by exposure to pollutants)
5. indirect, unorganized violence which decreases quality of life (i.e., cumulative workloads for working mothers)
6. organized, indirect, violence reducing quality of life (i.e., effects of the “NO SHOW” stamp in Primary Health Care).

Peace building requires more than avoiding all forms of violence. Brand-Jacobsen (2002) emphasizes building a culture of peace that prevents direct violence, changes structural violence, and promotes cultural diversity and inclusiveness to avoid cross-cultural conflict. Changing attitudes and behaviours to embrace diversity and fostering an open mind to conceptualize structures and processes that are grounded in peaceful principles would be a step beyond the recommended policy change.

CONCLUSIONS

In this article, I have shown that McLuhan's Laws of Media (McLuhan & McLuhan, 1988) was useful in identifying cultural factors beyond medical and epidemiologic causes that contribute to the health disparities encountered by Aboriginal peoples in Canada's North. The framework guided me to describe the taken-for-granted practice of using the "NO SHOW" stamp in a wider context. Through the analysis, I was able to describe how the abandoned Canadian assimilation policy is interconnected with contemporary nursing practice in primary health care. I emphasized this process by structuring the discussion with war theme headings, showing a path from tragedy and crises to approaches for future improvements. The "NO SHOW" stamp is one exhibit along this path. Many other practices may benefit from a similar analysis.

Further research is needed to show how these practices shape the experience and outcome of health for Aboriginal populations. Cultural studies and conflict analysis needs to complement the disease specific health research to understand health disparities. Likewise, cultural safety principles need to inform science-based nursing curriculums to strengthen caring. Policy changes such as the retirement of the "NO SHOW" stamp or introduction of cultural safety as the educational foundation for nurses will help create a more peaceful practice environment. The more colonial legacies are being put to rest, the easier it will become to address health disparities. However, real change will come from individual nurses by reflecting on personal attitudes and by understanding how their lives are shaped by human 'artefacts' and history, and by understanding how nurses shape their tools - from the words they use to the technologies they embrace.

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REFERENCES

- Anderson, J. & Reimer Kirkham, S. (1999). Discourses on health: A critical perspective. In H.G. Coward & P. Ratanakul (Eds.), *A cross-cultural dialogue on health care ethics*. Waterloo, ON: Wilfrid Laurier Press.
- Anderson, J., Perry, J.A., Blue, C., Browne, A., Henderson, A., Khan, K., et al. (2003). "Rewriting" cultural safety within the postcolonial and postnational feminist project: Toward new epistemologies of healing. *Advances in Nursing Science*, 26(3), 196-214. Retrieved September 11, 2008 from Academic Search Premier.
- Anderson, L.M., Scrimshaw, S.C., Fullilove, M.T., Fielding, J.E., Normand, J. & Task Force on Community Preventive Services. (2003). Culturally competent healthcare systems: A systematic review. *American Journal of Preventive Medicine*, 24(3S), 68-79. Retrieved July 21, 2009 via <http://scholar.google.com>.
- Andrews, M.-E., Stewart, N.J., Pitblado, J.R., Morgan, D.G., D'Arcy, C., & Forbes, D. (2005). Registered nurses working alone in rural and remote Canada. *Canadian Journal of Nursing Research*, 37(1), 14-33. Retrieved July 31, 2009 from IngentaConnect database.
- Arnold, O.F. (2004). Working in Aboriginal communities: What kind of health are we promoting? University of Victoria, BC: Unpublished manuscript.
- Arnold, O.F. & Bruce, A. (2005). Nursing practice with Aboriginal communities: Expanding worldviews. *Nursing Science Quarterly*, 18(3), 259-263.
- Ashcroft, B., Griffiths, G., & Tiffin, H. (1989). Introduction. In *The Empire writes back: Theory and practice in post-colonial literatures* (pp 2-12, online version).

- London, England: Routledge. Retrieved September 22, 2009 from <http://www.postcolonialweb.org/poldiscourse/ashcroft3a.html>.
- Atleo, M.R. (1997). First Nations healing: Dominance or health. *Canadian Journal for the Study of Adult Education*, 11(2). 63-77.
- Barrett, E.A. (2002). What is nursing science? *Nursing Science Quarterly*, 15(1), 51-60. Retrieved August 26, 2009 from Sage Journals Online database.
- Bjerregaard, P. & Young, T.K.. (1998). *The circumpolar Inuit: Health of a population in transition*. Copenhagen, Denmark: Munksgaard. Retrieved July 17, 2009 from <http://books.google.com>.
- Blackford, J. (2003). Cultural frameworks of nursing practice: exposing an exclusionary healthcare culture. *Nursing Inquiry*, 10(4), 236-244. Retrieved September 22, 2009 from Academic Search complete database.
- Brand-Jacobsen, K.F. (2002). Peace: The goal and the way. In J. Galtung, C.G. Jacobsen, & K.F. Brand-Jacobsen (Eds.), *Searching for peace: The road to TRANSCEND* (2nd ed., pp. 17-24). Sterling, VA: Pluto Press.
- Braveman, P. (2006). Health disparities and health equity: Concepts and measurement. *Annual Review of Public Health*, 27 (1), 167-194. Retrieved July 20, 2009 from <http://www.ops.org.bo/textocompleto/riarph270004.pdf>.
- Brennan, M. (1997). A concept analysis of consent. *Journal of Advanced Nursing*, 25(3), 477-484. Retrieved July 21, 2009 from Wiley InterScience database.
- Brilowski, G.A. & Wendler, M.C. (2005). An evolutionary concept analysis of caring. *Journal of Advanced Nursing*, 50(6), 641–650. Retrieved July 14, 2009 from EBSCOhost database.

- Brock-Utne, B. (1989). *Feminist perspectives on peace and peace education*. New York, NY: Pergamon Press.
- Browne, A.J. & Fiske, J.A. (2001). First Nations women's encounters with mainstream health care services. *Western Journal of Nursing Research*, 23(2), 126-147.
Retrieved September 11, 2008 from CSA Sage Health Sciences database.
- Brownlie, R.J. (2003). *A Fatherly Eye: Indian Agents, Government Power and Aboriginal Resistance in Ontario, 1918-1939*. Don Mills, ON: Oxford University Press. Retrieved July 16, 2009 from <http://books.google.com>.
- Buetow, S. (2007). Non-attendance for health care: When rational beliefs collide. *Sociological Review*, 55(3), 592-610. Retrieved July 24, 2009 from Academic Search Complete database.
- Canadian Broadcasting Corporation. (2009, July 20). *Swine flu hits young aboriginal residents hard, expert says*. Retrieved September 19, 2009 from <http://www.cbc.ca/canada/north/story/2009/07/20/aboriginal-flu.html>.
- Canadian Broadcasting Corporation. (2009, September 18). *Pandemic flu report overblown: health authority*. Retrieved September 19, 2009 from <http://www.cbc.ca/canada/british-columbia/story/2009/09/18/bc-pandemic-swine-flu-story-cmaj.html>.
- Canadian Health Services Research Foundation. (2006). *Myth: Medical malpractice lawsuits plague Canada*. Retrieved July 21, 2009 from http://www.chsrf.ca/mythbusters/pdf/myth21_e.pdf.
- Canadian Nurses Association. (2005). *Primary Health Care: A summary of the issues*. Ottawa, ON: Author. Retrieved July 17, 2009 from <http://www.cna->

[nurses.ca/CNA/documents/pdf/publications/BG7 Primary Health Care e.pdf](http://nurses.ca/CNA/documents/pdf/publications/BG7_Primary_Health_Care_e.pdf).

Capko, J. (2005). No-Shows cost plenty: Missed appointments mean decreased income and efficiency. *Humana's YourPractice* (Second Quarter). Retrieved August 10, 2009 from <http://www.humana.com/providers/NewsLetters/HumanaWeb2ndQ05/articles/noshows.html>.

College of Registered Nurses of British Columbia. (2007). *Nursing Documentation*. [Publication No. 151]. Vancouver, BC: Author. Retrieved July 20, 2009 from <http://crnbc.ca/downloads/151.pdf>.

College of Registered Nurses of British Columbia. (2008). *Documentation*. Practice Standard for Registered Nurse and Nurse Practitioners [Publication No. 334]. Vancouver, BC: Author. Retrieved July 20, 2009 from <http://crnbc.ca/downloads/334.pdf>.

Daiski, I. (2004). Changing nurses' dis-empowering relationship patterns. *Journal of Advanced Nursing*, 48(1), 43–50. Retrieved February 10, 2009 from Academic Search Premier database.

Denzin, N.K. & Lincoln, Y.S. (Eds.). (2005), *The Sage handbook of qualitative research* (3rd ed.). Thousand Oaks, CA: Sage Publications.

Doane, G.H. & Varcoe, C. (2007). Relational practice and nursing obligations. *Advances in Nursing Sciences*, 30(3), 192-205. Retrieved September 19, 2009 from Ovid database.

- Dorais, L.J. (1990). The Canadian Inuit and their language. In D.R.F. Collis, *Arctic language: An awakening* (pp. 185-291). Paris, France: UNESCO. Retrieved September 24, 2008 from <http://unesdoc.unesco.org/images/0008/000861/086162e.pdf>.
- Dworkin, G. (2009). Paternalism. In E N. Zalta (ed.), *The Stanford Encyclopedia of Philosophy* (Summer 2009 Edition), 8p. Retrieved July 14, 2009 from <http://plato.stanford.edu/archives/sum2009/entries/paternalism>.
- Ellefsen, B., Kim, H.S., & Ja Han, K. (2007). Nursing gaze as framework for nursing practice: a study from acute care settings in Korea, Norway and the USA. *Scandinavian Journal of Caring Sciences*, 21(1), 98-105. Retrieved October 20, 2009 from Wiley InterScience database.
- Field, C. (Director/Co-Producer). (2006). *¡Salud! What puts Cuba on the map in the quest for global health* [Motion Picture]. United States: MEDICC.
- Forsythe, D.P. (2005). *The humanitarians: the International Committee of the Red Cross*. New York, NY: Cambridge University Press. Retrieved September 2, 2009 from <http://books.google.com>.
- Gabriele, S. & Stober, J.A. (2007). *Old Messengers, New Media: The Legacy of Innis and McLuhan*. Retrieved July 14, 2009 from <http://www.collectionscanada.gc.ca/innis-mcluhan/index-e.html>.
- George, A. & Rubin, G. (2003). Non-attendance in general practice: a systematic review and its implications for access to primary health care. *Family Practice*, 20(2), 178–184. Retrieved July 28, 2009 from Oxford Journals database.

- Gruen, R.L., Weeramanthri, T.S., Knight, S.S., & Bailie, R.S. (2009). Specialist outreach clinics in primary care and rural hospital settings. *Cochrane Database of Systematic Reviews*, 2009 (3). Retrieved July 14, 2009 from The Cochrane Library database.
- Health Canada. (2007). History of Providing Health Services to First Nations people and Inuit. In *About Health Canada*. Retrieved July 16, 2009 from <http://www.hc-sc.gc.ca/ahc-asc/branch-dirgen/fnihb-dgspni/services-eng.php>.
- Health Disparities Task Group of the Federal/Provincial/Territorial Advisory Committee on Population Health and Health Security. (2004). *Reducing Health Disparities – Roles of the Health Sector: Discussion Paper*. Ottawa, ON: Public Health Agency of Canada. Retrieved September 19, 2009 from http://www.phac-aspc.gc.ca/ph-sp/disparities/pdf06/disparities_discussion_paper_e.pdf.
- Illich, I. (1976). *Medical Nemesis: The expropriation of health*. London, England: Caller and Boyars.
- Illich, I. (2003). Medical nemesis. *Journal of Epidemiology and Community Health*, 57(12), 919-922. Retrieved August 16, 2009 from BMJ Journals database.
- Institute of Aboriginal Peoples' Health. (2009). Institute of Aboriginal Peoples' Health (IAPH). In *Canadian Institutes of Health Research*. Retrieved July 20, 2009 from <http://www.cihr-irsc.gc.ca/e/8668.html>.
- Izard, T. (2005). Managing the habitual no-show patient. *Family Practice Management*, 12(2), 65-66. Retrieved September 11, 2008 from Academic Search Premier database.

- Johnson S.L. (2009). International perspectives on workplace bullying among nurses: a review. *International Nursing Review*, 56(1), 34–40. Retrieved July 31, 2009 from Wiley InterScience database.
- King, T. (2003). What is it about us that you don't like? In *The truth about stories: A Native narrative* (pp 121-151). Toronto, ON: Anansi Press.
- Kondro, W. (2009, September 17). Swine flu breaks out on Vancouver Island. *Canadian Medical Association Journal* [online report]. Retrieved September 19, 2009 from http://www.cmaj.ca/earlyreleases/17sept09_swine_flu_vancouver.shtml.
- Krebs, M. (2008). "Sorry" for genocide? Residential school apology in context. *The Dominion*, 53(August 2008). Retrieved September 2, 2009 from <http://www.dominionpaper.ca/articles/1928>.
- Krieger, N. (2003). Does racism harm health? Did child abuse exist before 1962? On explicit questions, critical science, and current controversies: An ecosocial perspective. *American Journal of Public Health*, 93(2), 194-199. Retrieved July 20, 2009 from <http://www.ajph.org/cgi/reprint/93/2/194>.
- Lacy, N.L., Paulman, A., Reuter, M.D., & Lovejoy, B. (2004). Why we don't come: Patient perspectives on no-shows. *Annals of Family Medicine*, 24(6), 541-545. Retrieved September 11, 2008 from Academic Search Premier database.
- Martin, C., Perfect, T., & Mantle, G. (2005). Non-attendance in primary care: The view of patients and practices on its causes, impact and solutions. *Family Practice*, 22(6), 638-643. Retrieved September 18, 2008 from EBSCOhost database.
- McLuhan, M. & McLuhan, E. (1988). *Laws of media: The new science*. Toronto, ON: University of Toronto Press.

- Miller, R.B. (2003). *Children, ethics, and modern medicine*. Bloomington, IN: Indiana University Press. Retrieved July 13, 2009 from <http://books.google.com>.
- Mullaly, B. (2002). *Challenging oppression: A critical social work approach*. Don Mills, ON: Oxford University Press.
- Oudshoorn, A., Ward-Griffin, C., & McWilliam, C. (2007). Client–nurse relationships in home-based palliative care: a critical analysis of power relations. *Journal of Clinical Nursing*, 16, 1435–1443. Retrieved February 10, 2009 from Academic Search Premier database.
- Platt, V. (2006a). Making an impression: Replication and the ontology of the Graeco-Roman seal stone. *Art History*, 29(2), 233 – 257. Retrieved July 14, 2009 from Wiley InterScience database.
- Platt, V. (2006b). Making an impression: Replication and the ontology of the Graeco-Roman seal stone [Abstract]. Retrieved July 14, 2009 from Wiley InterScience database.
- Quillian, L. (2006). New approaches to understanding racial discrimination and prejudice. *Annual Review of Sociology*, 32(1), 299-328. Retrieved July 22, 2009 from EBSCOhost database.
- Ramsden, I.M. (2002). *Cultural Safety and Nursing Education in Aotearoa and Te Waipounamu*. Wellington, Australia: Victoria University. Retrieved July 20, 2009 from <http://kawawhakaruruhau.massey.ac.nz/RAMSDEN%20THESIS.pdf>.
- Reimer Kirkham, S. (2003). The politics of belonging and intercultural health care. *Western Journal of Nursing Research*, 25(7), 762-780. Retrieved July 30, 2009 from SAGE Journals online database.

- Royal Commission on Aboriginal Peoples. (1996). *People to people, nation to nation: Highlights from the report of the Royal Commission on Aboriginal Peoples*. Retrieved July 7, 2009 from <http://www.ainc-inac.gc.ca/ap/pubs/rpt/rpt-eng.asp>.
- Saukko, P. (2005). Methodologies for cultural studies: An integrative approach. In N.K. Denzin & Y.S. Lincoln (Eds.), *The Sage handbook of qualitative research* (3rd ed., pp. 343-356). Thousand Oaks, CA: Sage Publications.
- Storch, J.L., Rodney, P., Pauly, B., Brown, H. & Starzomski, R. (2002). Listening to nurses' moral voices: building a quality health care environment. *Canadian Journal of Nursing Leadership*, 15(4), 7-16. Retrieved September 26, 2009 from Longwood Publishing database.
- Sweet, M. (2009). Is the media part of the Aboriginal health problem, and part of the solution? *Inside Story*, (March 3, 2009). Retrieved August 20, 2009 from <http://inside.org.au/part-of-the-aboriginal-health-problem>.
- Treaty No. 6 between Her Majesty the Queen and the Plain and Wood Cree Indians and other Tribes of Indians at Fort Carlton, Fort Pitt and Battle River.* (1876). Retrieved October 20, 2009 from <http://www.ainc-inac.gc.ca/al/hts/tgu/pubs/t6/trty6-eng.asp>.
- United Nations. (1948). *Convention on the Prevention and Punishment of the Crime of Genocide*. Retrieved September 2, 2009 from <http://www.hrweb.org/legal/genocide.html>.

- Waldram, J.B., Herring, D.A., & Young, T.K. (1995). *Aboriginal health in Canada: Historical, cultural, and epidemiological perspectives*. Toronto, ON: University of Toronto Press.
- Wikiquote. (2009). *Peace*. Retrieved October 20, 2009 from <http://en.wikiquote.org/wiki/Peace>.
- Wood, P.K. & Gilbert, L. (2005). Multiculturalism in Canada: Accidental discourse, alternative vision, urban practice. *International Journal of Urban and Regional Research*, 29(3), 679-691. Retrieved October 23, 2009 from Wiley InterScience database.
- World Health Organization. (1978). *Declaration of Alma Ata: International conference on Primary Health Care*. Retrieved Oct. 8, 2004 from: http://www.who.int/hpr/NPH/docs/declaration_almaata.pdf.
- Worster, A., Sardo, A., Thrasher, C., Fernandes, C., & Chemeris E. (2005). Understanding the role of nurse practitioners in Canada. *Canadian Journal of Rural Medicine*, 10(2), 89-94. Retrieved July 21, 2009 from http://www.cma.ca/index.cfm/ci_id/43590/la_id/1.htm.
- Young, E. & Quinn, L. (n.d.). *The policy brief*. Retrieved September 19, 2009 from http://sciencepolicy.colorado.edu/students/envs_5120/young_and_quinn.pdf.
- Young, L.E. (2002). Transforming health promotion practice: Moving toward holistic care. In L.E. Young & V. Hayes (Eds.), *Transforming health promotion practice: Concepts, issues, and applications* (pp. 3-21). Philadelphia, PA: F.A. Davis.

APPENDIX A

Briefing Note

GOVERNMENT OF NUNAVUT DEPARTMENT OF HEALTH AND SOCIAL SERVICES BRIEFING NOTE

TITLE: “NO SHOW” stamp

ISSUE: Whether to continue the use of the “NO SHOW” stamp in health centres for recording non-attended appointments.

POSITION:

- The department is committed to set standards in health care that incorporate Inuit Qaujimajatuqaniguit at all levels of service delivery for the health and well-being of all Nunavummiut (HS&S Mission Statement).

RECOMMENDED SPEAKING POINTS

- I am pleased to announce a policy change at the operational level that eliminates the use of the “NO SHOW” stamps in all health centres. Recording non-attendance of medical appointments in personal health records as well as in a database is redundant.
- This policy change reduces the stigma for patients who choose not to attend their medical appointments. This step is congruent with Inuit Qaujimajatuqaniguit (IQ)²⁴ and the Pinasuaqtavut 2004-2009²⁵.

²⁴ A set of guiding principles that reflect Inuit knowledge and societal values. The IQ framework is used to inform how government should deliver programs and services.

- The decision for this policy change is based on the IQ guiding principles of Tunnganarniq (fostering good spirit by being open, welcoming and inclusive) and Inuuqatigiitsiarniq (respecting other, relationships and caring for people).
- This policy change will not have any cost implications for the department. We will achieve a small cost reduction by not replacing the “NO SHOW” stamps and supplying fewer inkpads to all health centres in Nunavut.

CURRENT STATUS:

- The Health Centres continue to use the “NO SHOW” stamp to record and document non-attended medical appointments in personal health records.
- Attendance records are being electronically recorded in the appointment management database. The database provides data for planning of clinic operations and for statistical analysis.
- The department is working towards electronic health records. With the introduction of electronic health records, the stamp use will become obsolete.
- The no-show entry is an administrative record. It is a questionable part of a personal health record.
- The use of the “NO SHOW” stamp has discriminatory connotations. Nobody has formally challenged them to date.

OTHER OPTIONS (not recommended):

- Maintain status quo.
- Conduct a comprehensive review of all operational policies in health centres to study their congruency with Inuit Qaujimajatuqaniguit. This option is not recommended due to the diversity in institutional cultures between regions and individual health centres. The scope of such a study would be too broad to be feasible and very time and cost intensive.

BACKGROUND:

²⁵ The Government of Nunavut commitment to building Nunavut’s future. It is a long term plan setting out goals for the development of the new territory based on Inuit societal values (<http://www.gov.nu.ca/pinasuaqtavut/engcover.pdf>).

- The use of the “NO SHOW” stamp has become practice in health centres across Nunavut before the devolution of health care delivery to the Government of Nunavut from the Medical Services Branch of Health Canada.
- Personal health records are a professional and legal documentation of interactions between patients and health care providers. It includes history of the illness, the findings of the physical examination, the diagnosis, and a plan for treatment and evaluation. The no-show entry does not meet those criteria.
- The use of the stamp in personal health records contributes to negatively labelling and stereotyping patients who choose not to attend medical appointments. The entry in the personal health record does not document personal circumstances. The use of the stamp also creates a visual effect in a personal health record that stands out from all other entries. Stereotyping and generalizations lead to discrimination. This is particularly relevant in a postcolonial context where the majority of nurses and health care providers are non-Inuit.
- Non-attendance rates in health centres are reportedly high. There are no compiled statistics for Nunavut available at this time. Individual health centres are addressing the issue with local initiatives. However, removing stigma and creating a respectful, welcoming, and inclusive atmosphere in the health centres at the policy level is one factor that will help improve attendance rates.
- Individual patients have protested against the rigidity of the medical appointment system in the health centres with the claim that personal circumstances are not always being respectfully honoured.
- Nurses working in Nunavut are informed about IQ during their orientation. There is no ongoing evaluation of cultural competency in their practice.
- Refer to the attached paper for a scholarly discussion of the issue