

Northern Expressions: Understanding Collaboration  
in Northern Canadian Nurses' Practice

by

Anna Marie Beals  
BScN, University of Victoria, 1998

A Thesis Submitted in Partial Fulfillment of the  
Requirements for the Degree of

MASTER OF NURSING

in the Faculty of Human and Social Development

© Anna Marie Beals  
University of Victoria

All rights reserved. This thesis may not be reproduced in whole or in part, by  
photocopy or other means, without the permission of the author.

Supervisor: Dr. Marjorie MacDonald

ABSTRACT

In Canada's Northwest Territories nurses work primarily with and in First Nations' isolated and semi-isolated communities and are expected to practice at an advanced level. Collaboration is one competency standard identified by the Canadian Nurses Association as necessary for advanced practice. The notion that collaboration competency can be understood as a standard by which advanced nursing practice is defined becomes problematic when culture, language, and unique situations surrounding health in northern communities impact on nursing practice. This research explores and describes how northern nurses experience, understand, and engage in collaboration in their practice and endeavors to bring to light the contextual influences that impact collaborative northern nursing practice.

## Table of Contents

Title Page .....	i
Abstract.....	ii
Table of Contents .....	iii
List of Tables .....	iv
Acknowledgements .....	vi
Dedication .....	viii
Chapter 1 – Introduction.....	1
The Community and Cultural Context of Northern Nursing .....	3
Advanced Nursing Practice.....	7
Canadian Nurses Association Framework.....	9
Purpose and Utility of the Research.....	11
Chapter 2 – Literature Review .....	13
Aboriginal Health - Traditional Medicine to Colonial Medicine .....	13
Traditional Practices .....	13
Colonial Influence .....	15
First Nations Access to Health Care.....	17
Nursing and First Nations Health .....	23
The Nurse’s Role .....	24
Nursing Education in Preparation for the Role.....	27
Collaboration in Northern Nursing Practice.....	30
Chapter 3 – Methodology .....	35
Research Design .....	37
Participant Selection .....	38
Data Collection .....	39
Data Analysis.....	40
Ethics and Politics of the Research .....	42
Trustworthiness.....	45
Chapter 4 – Findings.....	48
Themes from the Data .....	48

Participants' Experiences with Collaboration.....	49
Culture.....	50
Language.....	55
Relationships.....	58
Communication.....	62
Conflict.....	67
Education.....	71
Formal Education.....	73
Informal Education.....	75
Summary.....	76
Chapter 5 – Discussion.....	79
Cultural Theory.....	79
Implications for Nursing.....	80
Implications for Policy.....	83
Implications for Research.....	85
Conclusion.....	85
References.....	87
Appendix A: Telephone Script for Recruiting Participants.....	93
Appendix B: Participant Consent Form.....	97
Appendix C: Sample Interview Questions.....	101
Appendix D: Ethics Approval.....	103

## LIST OF TABLES

Table 1: Generated Themes.....	49
--------------------------------	----

## ACKNOWLEDGEMENTS

The completion of this thesis would not have been possible without the support and involvement of several people. First and foremost I want to thank the nurses who participated in this research project. Your honesty, dedication, and love of northern nursing were evident in the discussions we shared.

I would like to acknowledge the following:

My supervisor Dr. Marjorie MacDonald for her belief in my ability, her expertise in the profession of nursing, and her valuable editing skills. Thank you for your sense of humour and friendship throughout this process.

The patience and understanding shown to me by my committee members: Dr. Mary Ellen Purkis, Dr. Jessica Ball, and Dr. Leslie Saxon.

Thank you to Mom and Dad – for your support throughout my nursing career.

To Rosita and Ed Alexander – the completion of this thesis would not have been possible without you.

To Sonya Rinzema – who was there as a fellow student and most of all as a friend who believed we would finish graduate school no matter what.

To Gia Alexander – for her insanity, playfulness, and those ears for listening.

To Karen and John Benwell who let me go “hunting” in their freezer so I would have the energy to continue.

To my husband Danny Beals for his unwavering support and his ironic sense of humour that put my world back into perspective when the thesis process seemed overwhelming.

Throughout the research and writing of this thesis, the support and guidance of so many friends and family was appreciated, and without you this project would not have reached fruition. Thank you.

DEDICATION

This thesis is dedicated to all nurses north of the 60<sup>th</sup> parallel.

## Chapter 1

### Introduction

In Canada's Northwest Territories (NT - or often referred to as north of the 60<sup>th</sup> parallel) nursing practice involves the nurse working primarily with and in First Nations' isolated and semi-isolated communities. As a nurse with several years of practice experience in these semi-isolated and isolated communities, I have always been interested in how northern nursing practice is affected by various Canadian mainstream institutions located south of the 60<sup>th</sup> parallel. These include institutions such as universities, colleges, and national, territorial, and provincial nursing associations. Over time, I realized that mainstream institutions located in urban areas of southern Canada usually develop not only educational programs, but also standards and policies affecting nursing practice in the north.

Nursing standards and policies influence and guide a nurse's practice no matter what the context of practice. In discussion with colleagues working in the Canadian northern territories and the southern provinces, I came to recognize that there are many contextual influences on northern practice and that these influences in the northern practice setting are accepted as the "norm" by nurses in these settings.

Due to geographic reality in the NT, northern communities tend to be isolated or semi isolated. This means that road travel to many communities is limited or non-existent, creating a situation in which community accessibility is achieved only by air or water transportation. When it comes to the organization and delivery of health programs, community members and nurses alike are often at the mercy of seasonal weather conditions and the uncertain availability of transportation craft.

Human resources are not readily available in the northern community health centers where nurses practice. For example, consultation in an emergency situation is done via telephone with a physician or other health care provider located in a facility several hundred kilometres from the health center. If the health center has three nurses available and four may be required to deal with the situation, or if another health care discipline such as respiratory therapy is needed, the nurse has no ready access to that resource and must manage the situation while keeping within her or his scope of practice.

Culture, language, and people's situations with respect to their health have an impact on how health and health care is viewed. NT communities have a population base of primarily First Nations' people and the nurse is often faced with health care situations intertwined with the culture of the communities. First Nations' people define what health means to them and therefore are experts of

their own health. Their experience with health and health care will have meanings that depend on their culture and situation. Because First Nations' people have their own definitions and experiences of health and healing, only they, within the context of family and community, can determine how healing will be accomplished, when healing is attained, or if healing is necessary at all.

### **The Community and Cultural Context of Northern Nursing**

To assist the reader in understanding the context in which northern nursing practice is situated, characteristics common to semi- and isolated NT communities will be presented. To protect the identities of the communities discussed by participants in this project and still provide context for the reader, the description of the communities is general.

Most NT communities have a local band office, Native Friendship Center, hamlet office, grocery store (either the Northern or the Co-op) that, more often than not, is also the local financial institution and provider of postal services, a Royal Canadian Mounted Police (RCMP) detachment, a senior citizens facility, an adult education center, a school that might accommodate kindergarten to grade 12 (depending on the number of students in the community), and a recreation center. The Social Services Office is usually located in the health center while other government and private agencies are located within various community venues. Private corporations supply electrical power, water is

trucked to the local businesses and residences, and sewage is removed from all buildings via pumps then trucked to the local sewage lagoon. Heating needs for businesses and residences are supplied by electricity, fuel oil, or wood. Technology services such as telephone and Internet are provided via the territorial communication system.

The majority of individuals live with their immediate family and/or with extended family, often creating over-crowding in the household. For example, there may be up to eight or more people living in a two-bedroom house. Many of the people speak an Aboriginal language as their first language, which is often not the case in southern First Nations communities where many of the younger community members do not speak their native language.

With the exception of people working for the band, regional governing bodies, or territorial and federal governments, community members are often left with no option but to find paid work outside of the community, usually in the mines or with the oil and gas industry. Most commonly, these are the men of the community and this leaves the women to cope with the day-to-day management of childcare, household activities, family concerns, and community issues.

Although there is much work being done in the addictions area, alcohol and drug abuse are prevalent throughout most of the communities. This abuse often leads to physical and sexual assaults, emotional abuse, and child neglect.

Health care services are under the mandate of the territorial government and administered via regional health authorities that are ultimately accountable for the delivery of health programs in individual communities. On a day-to-day basis, the provision of health programs is carried out by staff working in health centers located in the semi- or isolated community. With the exception of the larger centers that are located on the NT road system, most of the communities are isolated geographically from one another and accessible only by air or water transportation. This isolation presents daily challenges to the overall delivery of health care services. For example, if the stock of normal saline intravenous solution in the health center is depleted it can take days, if not weeks, for a supply to arrive by air or water transport and this is if the weather conditions are satisfactory. With temperatures dipping to minus 40 C in the winter months, weather conditions play a huge role as to when or if medevac teams can get into the community, or whether the delivery of supplies, transportation of health care staff, and transportation of clients to the larger centers for various medical appointments are possible.

One to seven nurses, depending on the population, provide most of the health care service available to the people living in the individual communities and their surrounding areas. The health center or nursing station, as it is often referred to by the local populace, is usually located in the center of the

community. Public health programs and a general clinic are held during regular business hours Monday to Friday, with access for emergency care after hours, weekends, and holidays. During general clinic, people see the nurses for minor ailments, suturing of lacerations, counselling, x-rays, blood work, and physical examinations for driver's license and the like. Other health services to the communities are provided by visiting disciplines such as physicians, eye technicians, dentists, and physiotherapists on a monthly to twice yearly basis.

It is not unusual for nurses to see up to twenty clients each during the course of a day and then to be on call for emergencies after hours. Being on call requires that one nurse would be the first to respond to all after hour phone calls with the likelihood of returning to the health center to see the person who called. If there is a second nurse available (depending on staffing numbers) she/he would assist the first nurse on call if necessary. If there is no other nurse available in the community, the nurse would rely on others in the community to assist, whether that be a social worker, an RCMP officer, or a member of the general public. Nurses working in the health centers are also expected to make monthly visits to the smaller or satellite communities that have no health center facility, and most of these communities are accessible only by air transport.

In providing twenty-four hour emergency service, primary medical services, community and public health programs, and nursing care on an

outpatient basis, the nurse in a northern practice setting must be continually aware of the need to include First Nations' health-related cultural practices as defined by the First Nations' people of that community, and to consider the cultural appropriateness of everything she or he does.

### **Advanced Nursing Practice**

Experience has shown me that in isolated and semi-isolated NT First Nations' communities, the nurse is expected to practice at an advanced level. Practicing at an advanced level, or advanced nursing practice (ANP) is described by the Canadian Nurses Association (CNA, 2002), as "...nursing practice that maximizes the use of in-depth nursing knowledge and skill in meeting the health needs of clients (individuals, families, groups, populations, or entire communities). In this way, ANP extends the boundaries of nursing's scope of practice and contributes to nursing knowledge and the development and advancement of the profession" (p.4).

Nurses practicing in the north come from various mainstream institutional educational programs and levels. Although they need to be practicing at an advanced level to provide appropriate care, they are often not prepared to function at the advanced level necessary in these northern communities (Gregory, 1992). For example, diploma and baccalaureate qualifications from a recognized educational institution prepare the nurse to

function as a generalist in the provision of health care to clients. This means that the nurse has the knowledge and skill level to meet the basic requirements for entry into nursing practice, and may have developed considerable expertise with long-term nursing experience.

Within the context of northern nursing practice, however, the nurse needs to possess comprehensive knowledge and ability to deliver health care services within the parameters of the different meanings, concerns, and experience of the Aboriginal people of a particular community. This goes beyond what nurses are educated to do in undergraduate nursing programs.

Practicing effectively in these communities includes the need to communicate skilfully and to collaborate in more complex and sophisticated ways with clients, nursing colleagues, and other health care practitioners, than is often the case in the south. The expectation is that the nurse will develop partnerships with clients and members of other disciplines to create a united effort in the delivery of health care at the systems level. This systems level functioning is a hallmark of advanced nursing practice (Pauly, Schreiber, MacDonald, et al., 2004) and is often what is missing in the practice of registered nurses who are not educated at a master's level.

## **Canadian Nurses Association Framework**

The Canadian Nurses Association (CNA) has developed an advanced nursing practice policy framework to establish competency standards that exemplify what constitutes ANP in Canada. By establishing competency standards, the framework proposes to describe and guide the development of ANP in its evolution. As well, the intent is to encourage registered nurses working in advanced practice to attain and maintain the level of competency required in their demanding and complex practice environments.

Within the framework are core competencies that nurses are expected to derive from the in-depth experience, knowledge, and expertise acquired over time in nursing practice (CNA, 2000). These competencies “serve as a foundation for ANP and a framework for defining specific competencies associated with different contexts of practice” and “are demonstrated in roles that require highly autonomous, independent, accountable, and ethical practice in complex, often ambiguous and rapidly changing environments” (CNA, 2000, p.6). Collaboration is one competency standard identified by the CNA, and by provincial and territorial nursing associations, as necessary in ANP. Although collaboration is required by entry-level registered nurses, the nature of collaboration by advanced practice nurses is intended to be more sophisticated and take place at a “higher level” than by registered nurses. The notion, however, that the CNA

collaboration competency can be understood as a standard by which ANP is defined becomes problematic when culture, language, and circumstances surrounding health in northern communities impact on nursing practice.

Nurses who are responsible for the provision of health care services to First Nations' communities are confronted with the concern of not only being knowledgeable and educated about First Nations' cultures, but also with ensuring the services are culturally competent/appropriate (Kavanagh, Absalom, Beil, & Schliessmann, 1999; Pence & McCallum, 1994). Campinha-Bacote as cited in Kavanagh et al. (1999) define cultural competence as "a set of congruent behaviors, attitudes, and policies that come together in a system or agency, or among professionals, and enable that system, agency, or (those) professionals to work effectively in cross-cultural situations" (p.12). Reciprocal understanding of values and beliefs that may be brought to a collaborative relationship among First Nations' communities, practitioners, and professional organizations such as the CNA is central to the success of culturally competent programs and health service delivery in First Nations' communities. The CNA competencies do not explicitly incorporate the recognition of cultural differences, and practicing in a northern First Nations' community requires the nurse to integrate cultural views in providing health and health care to community members. This leads to the question: does the CNA collaboration competency framework adequately reflect

nursing practice experienced in northern isolated and semi-isolated First Nations' communities?

### **Purpose and Utility of the Research**

The purpose of this research is: (a) to explore and describe how nurses in a First Nation community in Canada's NT experience, understand, and engage in collaboration in their practice, and (b) to compare their experiences and understanding of collaboration with the collaboration competencies outlined in the CNA framework for ANP. In understanding how nurses comprehend collaboration, the research will endeavour to bring to light the contextual influences that impact collaborative nursing practice by discovering the challenges and supports present within the nurses' practice in a First Nation NT community. The researcher hopes to challenge and expand the understanding of collaboration reflected in the CNA framework.

Within the constructivist paradigm, a phenomenological approach was chosen for this research. A premise of this paradigm is that there is no objective reality in the social world. Thus, research within this paradigm involves finding out from each participant "...how each of their different experiences or ideas is part of constructing, bringing into being, the phenomenon which you are investigating" (Jackson, 1991, p.2). In this project, the lived experiences of nurses' collaboration in their practice north of the 60<sup>th</sup> parallel will be explored. A

phenomenological approach allows me, the researcher, to explicate the meaning of lived experiences in the context of an individual's life world (van Manen, 1997).

This research has the potential to contribute to the ongoing development of our understanding of the nature of advanced nursing practice in Canada, particularly as it relates to practice in northern Canada in First Nations' communities. As well, the project will provide nurses practicing in Canada's far north with the opportunity to share their knowledge, reflect on, and gain a deeper understanding of their own collaborative nursing practice.

Chapter one of this thesis has provided the reader with a general overview of the research project. Chapter two offers a review of the literature as it pertains to this project. Chapter three describes the methodology, research design, participant selection, and a description of the data collection and analysis used in this research. The ethics and politics of the research and trustworthiness of the research design are also included in chapter three. Chapter four contains the findings of the research, and chapter five presents a discussion of the findings.

## Chapter 2

### Literature Review

#### **Aboriginal Health - Traditional Medicine to Colonial Medicine**

##### *Traditional Practices*

Despite the rhetoric that health programs and health service providers (e.g., nurses) are culturally competent in relation to First Nations people's health care, this is often not consistent with the experience of First Nations' communities. First Nations' cultural and health-related values and beliefs are usually addressed in documents (nursing literature, nursing policy, job descriptions for example) by the addition of "...a few cultural artefacts to make it culturally appropriate" (Pence & McCallum, 1994, p111). As stated earlier in chapter one, this is not what is meant by cultural competence in this thesis. To understand the impact that the imposition of Euro-Western methods of health care have had on Aboriginal people, nurses need to comprehend that traditional First Nations' healing practices were established and were effective long before the health care programs and systems that are so familiar to us today.

Tradition is defined in Collins Concise (1995) dictionary as " 1. the handing down from generation to generation of customs, beliefs, etc. 2. the body of customs, thought, etc., belonging to a particular country, people, family, or institution over a long period. 3. a specific custom or practice of long standing"

(p.1429). Cultural beliefs and values surrounding traditional Aboriginal healing practices and customs vary among First Nations people. However, one commonality among First Nations people is the oral tradition. From generation to generation, First Nations peoples' traditional medicine practices and customs have been handed down orally to and provided by " . . . medicine men/women, shamans, midwives, bone setter, and herbalists" (Canitz, 1990, p. 194). Unlike other ancient healing systems such as Chinese medicine, the First Nations people did not document their use of medicinal plants from the land, traditional ways of healing, and the ceremonies that were often part of traditional medicine (O'Neil, 1993). By the standards of health care providers in the western world, this lack of documentation may possibly contribute to the lack of understanding about and acceptance of the validity of First Nations' traditional medicine.

In traditional medicine, First Nations people embrace " ...an holistic understanding that integrates health-related phenomena into an inclusive, circular path or journey of living and dying" (Kavanagh, Absalom, Beil, & Schliessmann, 1999). As suggested by historical findings, the perspective of harmony and balance relating to health and healing probably contributed to the vitality of First Nations people's physical and mental well-being prior to contact with the Europeans (Report of the Royal Commission on Aboriginal Peoples, 1996).

Although Aboriginal traditional healing practices have interested some external observers, the writings analyzing First Nations traditional medicine offer interpretations that fit the explanatory frameworks of the external observers rather than being disinterested or objective observations (O'Neil, 1993, p. 37). From the perspective of anthropologists, First Nations' traditional medicine has been described " . . . as a mechanism of social control, in an effort to provide a 'rational' explanation for a phenomenon that to the western scientific mind is 'irrational' and unintelligible" (O'Neil, 1993). This mind set appears to have been that of European travelers who ridiculed traditional medicine, and also of early Christian missionaries who viewed First Nations healing practices as witchcraft and idolatry (Report of the Royal Commission on Aboriginal Peoples, 1996). However, as pointed out by O'Neill (1993), rarely have there been attempts made at understanding First Nations peoples' traditional medicine and healing practices in the context, and from the perspective of, First Nations traditional medicine practitioners.

### ***Colonial Influence***

Prior to contact with Europeans, First Nations people were relatively disease free. The Royal Commission on Aboriginal People (1996) comments on evidence found by modern paleo-biologists:

Skeletal remains of unquestionably pre-Columbian date...are, barring a few exceptions, remarkably free from disease. Whole

important scourges (affecting Europeans during the colonial period) were wholly unknown....There was no plague, cholera, typhus, smallpox or measles. Cancer was rare, and even fractures were infrequent.... There were, apparently, no nevi (skin tumors). There were no troubles with the feet, such as fallen arches. And judging from later acquired knowledge, there was a much greater scarcity than in the white population of...most mental disorders, and of other serious conditions. (p.111).

With the arrival of the European people also came disease-carrying micro-organisms foreign to the systems of First Nations people (Di Marco & Storch, 1995). Until then, First Nations people had lived with and developed resistance to the micro-organisms in their habitat, and were able to treat disease and injury with medicinal plants and other therapies common to their environment (Report of the Royal Commission on Aboriginal Peoples, 1996). With the introduction of smallpox, influenza, measles, polio, diphtheria and other diseases, traditional medicine and healing practices were of little or no benefit in the prevention or treatment of illness (Report of the Royal Commission on Aboriginal Peoples, 1996). Thus began the decline of a people who once lived in harmony with the land that supplied them with food, clothing, a traditional economy, and products necessary for health and healing.

Leaders of First Nations people were aware that the poor health and economy of their people was associated with the arrival of Europeans and rampant disease affecting the once strong First Nations' communities. In an attempt to protect their people from disease and further destitution, First Nations

leaders entered into treaty agreements with representatives of the British Crown (Report of the Royal Commission on Aboriginal Peoples, 1996). With the signing of these written agreements, the transformation of healthy independent First Nations people to people stricken with disease began with the result that a “ . . . once-mobile peoples...(being) confined to small plots of land where resources and opportunities for natural sanitation were limited. It worsened yet again as long-standing norms, values, social systems and spiritual practices were undermined or outlawed” (Report of the Royal Commission on Aboriginal Peoples, 1996, p. 113).

First Nations people were slowly stripped of self respect as their ceremonies were outlawed, elders and healers were prosecuted and blamed for disease affecting their communities, their lands and resources were taken over for use by European settlers, and hunters and trappers were coerced into working as agricultural labourers for wages (Report of the Royal Commission on Aboriginal Peoples, 1996.) These factors lead to First Nations peoples becoming dependent on government departments, which often operate semi-autonomously, for social programs and health care.

### ***First Nations Access to Health Care***

As a result of treaties signed with the federal government of Canada in the 1800's, the administration and delivery of health services has been a political

issue for First Nations' people (Goodwill, 1992). The "Medicine Chest Clause" contained in Treaty 6 is interpreted by First Nations' people to mean that health services would be provided to all First Nations' people whenever they needed them, and be appropriate to services available at the time (Favel-King, 1993, Goodwill, 1992). The clause reads "That a medicine chest shall be kept at the house of each Indian agent for the use and benefit of the Indians at the direction of such agent" (Internet, Queen's Printer, 2002). Due to differing interpretations, the "Medicine Chest Clause" has been a source of contention between First Nations people and the Canadian federal government for several years (Favel-King, 1993).

First Nations people have interpreted the clause to mean that the federal government would provide people of First Nations with a health care plan delivering services equal to those available to other Canadians (Goodwill, 1992). These health care services would include "... curative, mental health care, preventive and promotion services, essential medications, hospital care, ambulance services, diagnostic services, optometric and dental care, and medical appliances..." (Goodwill, 1992, p.598).

In an Indian and Northern Affairs Canada document (Internet, Queen's Printer, 2002) in the discussion of the Treaty 6 Medicine Chest Clause it states that "... Such limitation would indicate that the obligation was to have

physically on the reservations, for the use and benefit of the Indians, a supply of medicine under the supervision of the agent.... nothing historically, or in any dictionary definition, or in any legal pronouncement, that would justify the conclusion that the Indians, in seeking and accepting the Crown's obligation to provide a "medicine chest" had in contemplation provision of all medical services, including hospital care". According to this reading, it could be understood that the Canadian federal government interprets the clause to mean that the government is responsible for providing only medicine and no other health programs or services to First Nations' people. Favel-King (1993) uses the metaphor of a first aid kit to describe the federal government's interpretation of the clause.

Regardless of interpretation, First Nations people in Canada do not have equal access to the social programs and health care services available to the majority of Canadians (Goodwill, 1992; Report of the Royal Commission on Aboriginal Peoples, 1996; Scott, 1993). Health care services to First Nations people were provided by the Canadian federal government first by "... an assortment of semi-trained RCMP agents, missionaries and officers, and later by a growing number of nurses and doctors... employ(ed) by the federal government" (Royal Commission on Aboriginal Peoples, 1996, p. 114).

Until the mid 1940's the federal government Department of Indian Affairs and Northern Development (DIAND) was responsible for health services to people of First Nations (Favel-King, 1993). DIAND then transferred responsibility for health service delivery to people of First Nations to Health and Welfare Canada, Medical Services Branch (MSB), and for the last 30 to 40 years, health services to First Nations people has been financed and delivered by the MSB (Favel-King, 1993, Sutherland & Fulton, 1990).

In the delivery of health care to First Nations' people "services operated or funded by the MSB include... preventive, diagnostic, treatment and educational programs in the fields of dentistry, medical care, public health and environmental health" (Sutherland & Fulton, 1990, p.54). Factors affecting the overall well-being and health of First Nations people and funding for community systems remains the responsibility of DIAND. These factors include " . . . areas with a direct relation to health status, such as roads, housing, and water and sewer systems, as well as financial assistance to cover such basic needs as food, clothing, shelter and what the department refers to as adult care" (Favel-King, 1993, p. 121).

The MSB and DIAND are but two federal government bodies with responsibility of ensuring that health care and related services are provided to people of the First Nations. Because various other federal government bodies

have related responsibilities and roles in First Nations health care and associated services, planning and integrating services become very complex. Often, services are duplicated, excessive funds are spent on rectifying problems that could have been avoided with adequate planning and communication and lack of common goals among the departments deter from meeting the needs of First Nations people (Favel-King, 1993).

Although the MSB and DIAND are responsible for the health care of First Nations people, their mandates appear to be different. This is especially evident when it comes to the treaty rights of health. Clearly stated in Favel-King (1993) is MSB's view that:

... the responsibility for discussing treaties on behalf of the federal government resides with DIAND. Where DIAND has received a mandate to discuss treaty matters with First Nations, and if the treaty matters to be discussed include health, the Department of National Health and Welfare, through MSB, will participate in that substantive discussion. MSB participation will be subject to the overall DIAND mandate and framework for treaty discussions (p.122).

DIAND on the other hand, gives full responsibility to MSB when treaty rights to health are discussed. The argument, presented by DIAND, is that since MSB is responsible for the direct health care and services provided to First Nations people, MSB should therefore be responsible for negotiating treaty rights to health (Favel-King, 1993).

More recently, the MSB has been reorganized and renamed the First Nations and Inuit Health Branch (FNIHB). As well, people of First Nations across Canada are in the process of having the administrative function of health care transferred to the bands and native councils of First Nations' communities (Sutherland & Fulton, 1990). However, the implications of health care transfer are extremely complex and beyond the scope of this thesis.

The Government of Canada of the time assumed that First Nations people would embrace this colonial style or Euro-western method of health care. Because of the high level of infectious diseases present in First Nations' communities and the immediate positive impact made by medical treatment of the disease process, First Nations' people did accept the western style of health care (Royal Commission on Aboriginal Peoples, 1996). However, benefits of the medical treatment provided by the federal government had drawbacks. In order to receive medical treatment for serious illnesses, First Nations people were often transported to larger centers located in environments foreign and often hostile to them. Health care providers, both in larger centers and in First Nations' communities, were non-Aboriginal, did not understand or dismissed First Nations' cultural health practices or values, and "encounters were often clouded by suspicion, misunderstanding, resentment and racism" (Royal Commission on Aboriginal Peoples, 1996, p.114). The health services offered to First Nations

people in their own communities was not grounded in the local values and beliefs, traditional practices, and service providers did not speak the language native to the people of the community. Devaluing of traditional healing practices by the Euro-western medical service providers compelled First Nations healers to practice in secrecy, if at all, and gradually some knowledge of traditional healing practices was lost (Royal Commission on Aboriginal Peoples, 1996).

Over time, Aboriginal people have learned that they do not have to be on the receiving end of having their cultural beliefs and values about health care defined for them by various government bodies and service providers. As health care providers, nurses and their professional organizations can augment a culturally competent nursing practice by attaining an awareness that "...understanding, negotiation, and preservation of cultural health-related beliefs and practices fosters self-efficacy and treatment adherence..." (Kavanagh et al., 1999, p.12).

### **Nursing and First Nations Health**

As well as being responsible for the services previously mentioned, the MSB (now FNIHB) was responsible for maintaining nursing stations and health centers. In the early 1930's the first nursing station was established by the federal government based on a humanitarian ideology driving the emerging Canadian welfare state and in response to the epidemic of tuberculosis in First Nations

communities (Royal Commission of Aboriginal People, 1996). Because of the lack of community-based medical services by physicians, nurses have primarily been the backbone of health care delivery services to isolated and semi-isolated First Nations communities in Canada (Gregory, 1992; Morewood-Northrop, 1994).

### *The Nurse's Role*

Working in First Nations' communities places nurses within cultures often different from their own, in communities that are geographically isolated, and they are separated for extended periods of time from family and friends. Living accommodations for nurses are located either in the nursing station or in a residence-style complex. The living accommodations provided for nurses are equipped with the amenities of modern day living such as plumbing, central heating, appliances, and electricity. Often the living quarters of nurses are above the standard of living experienced by members of the community in which the nurses live and work. This difference in living standards can distance and thus isolate the nurse from members of the community in which the nurse lives and works. Also contributing to alienation from community members is the nurse's lack of visible participation in community activities and often only associating with other professionals who are usually non-Aboriginal (Gregory, 1992).

Cultural differences can act as a barrier between the nurses and community members. As noted in Taylor's (1995) writings about teachers

working and living in First Nations communities, teachers had virtually no support or direction in understanding the culture into which they were expected to live and teach. This is very similar to what first time nurses arriving in First Nations communities can experience. Nurses from the south arriving in semi-isolated and isolated First Nations communities are likely to experience an unfamiliar environment, different sets of cultural values and beliefs, and social activities that are uncommon in most parts of southern Canada (Taylor, 1995).

Although First Nations nurses may experience a connectedness with native culture, possibly have a command of the language spoken, and have a deeper understanding of the socio-economic plight of community members, they encounter different issues than do non-Aboriginal nurses (Goodwill, 1992; Gregory, 1992). For example, a First Nations nurse, because of her/his knowledge of cultural differences, may experience resentment from non-Aboriginal colleagues causing strained relationships and alienation from each other (Goodwill, 1992). Because of hierarchical relationships and family dynamics within Aboriginal communities, the community will place different expectations on the First Nations nurse. If the nurse is from a particular family not accepted by the community, this may inhibit her/his ability to carry out her/his role effectively.

Outpost nurses are responsible for providing twenty-four hour emergency services, primary medical services, and nursing care on an out-patient basis for the community in which they work. As stated by Allen (1993), " the nurse...must work five days a week and be on call twenty-four hours a day, seven days a week, three hundred and sixty-five days a year" (p.137). Nurses act as resource people for the communities, and liaise with various community agencies such as social services, and the Royal Canadian Mounted Police. They communicate with physicians via telephone or in person when a physician visits the community. In many cases nurses are also expected to take on the role of pharmacist, environmental health officer, transport agent, and office clerk all the while providing health care to community members (Gregory, 1992) As well, nurses are responsible for the development and implementation of individual and community health programs that include but are not limited to pre-school screening, pre-natal programs, chronic care programs, well woman and well man clinics, immunization programs, and well child clinics (Gregory, 1992). In other words, the nurse is both primary care provider and public health nurse, in addition to carrying out the functions that other health and social service professionals provide in the south.

Historically, the MSB (now FNIHB) controlled health care services available to First Nation's communities through funding and health policies that

influence how health services are delivered. Although the territorial and federal governments fund the above mentioned community health programs and encourage primary health programs, the health system in semi-isolated and isolated First Nations communities (and in mainstream Canadian communities) remains treatment focused or curative (Gregory, 1992).

The heavy workload demands placed on the nurses often prevents them from engaging in the preventative programs that could help to improve overall health status of community members. Contributing to the lack of engagement in these programs is the conditioning of First Nations people through the paternalistic approach of the health care system (Gregory, 1992). First Nations people have come to expect a curative view of health and health care, and coupled with poor socio-economic conditions present in semi-isolated and isolated communities, nurses are challenged by having to work within these constraints (Gregory, 1992).

### ***Nursing Education in Preparation for the Role***

At minimum, nurses employed for outpost nursing station work must be graduates from a recognized school of nursing, registered for active practice in the Canadian province or territory of their employment, and possess at least one year clinical experience with a community health nursing diploma or nursing degree (Health and Welfare Canada application information brochure, nd). As

well, nurses in northern practice are expected to have additional clinical skills training in physical assessment, diagnostics, and also possess a cultural understanding of the Aboriginal people in the community where the nurse practices. This additional education is often provided in short-term education programs that do not provide credentials recognized by mainstream educational institutions, and thus do not substantially contribute to a nurse's overall career development.

In addition to the education required to practice at an advanced level, educational opportunities are essential to ensure that nurses working in isolated or semi-isolated First Nations communities are able to maintain and enhance their knowledge base to practice safely and ethically. Because of the range of expertise needed in these settings, nurses require continuing education to maintain clinical and cultural competence (Carberry, 1998; Gregory, 1992). Yet, nurses in these communities are provided with limited opportunities to attend workshops or other continuing education courses. As well, factors such as funding, staffing, and technological equipment often restrict the choice of and access to subject matter.

Courses designed to provide and enhance the knowledge required to practice in the northern setting are often based on a competency education system. Competency-based education is governed by objectives, requirements,

and criteria of adequacy that are defined externally to teachers and students (in this case nurses) and does not necessarily serve their purposes (Jackson, 1992). For example, although the Introduction to Nurse Practitioner (INP) program established by the Nursing Services Division, Department of Health, NT contributes to the education required by nurses working in the NT communities, the competency-based approach has been used politically to convince health administrators and the public that this type of education is efficient, effective, and responsive to learning needs of northern nurses (Jackson, 1992).

The use of competency based education/training (CBE/T) serves as a measurement tool for administrative accountability and shifts the priority from meeting learning needs of individuals within a given context (in this research, nurses in northern practice) to serving the needs of politicians, employers, and perhaps even professional territorial, provincial, and national nursing associations (Jackson, 1995). This organization of knowledge transfers education processes to administrators, providing them with a product that is measurable and can be accounted for fiscally (Jackson, 1995) and does not necessarily account for the needs of nurses and communities. Although some tension may be created by the question of who benefits in this process (i.e., individual versus the collective public), this education process does provide a level of trust and safety to the public. Because of the objective evaluation methods inherent in CBE/T the

nurse is held accountable and responsible for knowledge gained and in turn, for her practice (CNA, 2000; RNABC, 1998).

An approach to nursing education that might be more appropriate for preparing nurses to work in northern communities incorporates the notion of inclusion. Working in partnership, some First Nations' communities, practitioners, and academics have developed and implemented culturally competent programs using a constructionist pedagogical approach (Ball & Pence, 1999). Using this approach, teaching methods are governed by participatory learning, sharing of experiences through dialogue, and the use of critical reflexivity to help learners understand the complex relationships of culture and politics in a First Nations' community. Within the context of culturally competent education, the nurse and Aboriginal people are co-learners of health and health care. Both the nurse and the members of the First Nations' culture in which the nurse practices bring varied life experiences and knowledge to a situation. In the interaction between the two, knowledge is shared and provides the nurse and First Nations' people with an opportunity for a reciprocal teaching/learning experience (Kavanagh et al., 1999).

### **Collaboration in Northern Nursing Practice**

As with the reciprocal teaching/learning approach mentioned above, collaboration is a shared developmental process among individuals in daily

interpersonal interactions within their environment, and cannot be pre-planned by those not intimately involved in the collaborative process (Gardner & Cary, 1999; Stapleton, 1998).

Much of the literature about collaborative practice focuses on registered nurse-physician collaboration within the work place. Campbell, Daramola, and Dorris (1995) illustrate collaborative practice in an urban acute care setting with the focus on the nurse-physician relationship. The importance of communication in collaborative practice was presented by Milligan, Gilroy, Katz, Rodan, and Siva Subramanian (1999) with again, the nurse-physician relationship being central to the concept of collaborative practice. In a study by Dechairo-Marino, Jordan-Marsh, Traiger, and Saulo (2001), the focus on collaborative nursing practice was to improve nurse-physician collaboration in the work place in order to ...“change nurses’ ratings of collaboration and satisfaction with decision-making” (p.225).

Henneman, in Stapleton’s (1998) article presents an understanding that “collaboration is, in fact, a process which occurs between individuals, and only the persons involved ultimately determine whether or not collaboration occurs” (p.13). What this means for nurses working in northern First Nations communities is they must recognize that collaboration in northern nursing practice goes beyond the nurse-physician focus. As the nurse recognizes that the

collaborative process is a collective effort, she/he begins to have an understanding of what collaborative practice “looks like” for them and others in the northern community context. Davies and Hughes (1995) view collaboration in ANP as a vital component of leadership and creating awareness in other disciplines about nursing’s role in health care. They state that collaboration “... is also important in working toward change within the health care system for betterment of the care received within that system” (p.158).

Whether it be on an individual or systems level, working toward change frequently means that differences are brought to the forefront creating problems that need to be resolved and solutions sought after. These differences can create conflict, which is often viewed as destructive when addressing controversial issues. As stated by Gardner and Cary (1999), “many professions have not been socialized to understand the potential positive aspects of conflict and have great difficulty in dealing constructively with it at any level” (p.70). Within a collaborative practice, conflict can be seen as key to integrating differing perspectives and reaching creative solutions to various problems/challenges (Gardner & Cary, 1999). North of the 60<sup>th</sup> parallel, factors such as isolation, the unusually close proximity of living and working environments for nurses, cultural differences, and the transient nature of nursing practice and that of other

professions, create situations where collaboration in conflict resolution becomes a survival tool in the northern setting.

Effective communication, respect for the knowledge and practice of disciplines other than nursing, shared decision-making, conflict resolution, understanding relevant theories related to practice, and engaging in quality assurance programs are all characteristics of collaboration at the ANP level (CNA, 2000). Taking into consideration the various perspectives on the attributes of collaboration, one can begin to understand the complexity and challenges of the collaboration competency at the ANP level, particularly as it relates to practice in northern communities given the predominately First Nations' culture. (Gardner & Cary, 1999).

Within the northern context, all nurses practicing at the advanced level, to be competent, must engage in effective collaboration and this means explicit integration of the Aboriginal culture in health care. Although some nurses working in communities in the southern provinces of Canada work with First Nations' people, and experience isolation, different languages, beliefs, and values in their day-to-day practice, the majority of nurses in NT communities experience the rarity of being a stranger in their own county because of language and culture. This is not the same for nurses working in southern Canada.

Although nurses in Quebec must be bilingual in English and French to be licensed to practice in that province (CNA, nd), this is not so for nurses working in the north. Despite the fact that north of the 60<sup>th</sup> parallel eleven existing Aboriginal languages are officially recognized and acknowledged by the government of the NT, nurses are not obligated to speak or learn another language other than English in order to practice in the NT. Within this environment of “foreign” languages, the nurses work with interpreters on a daily basis. This presents particular challenges for northern nurses’ collaboration with the people of their communities.

## Chapter 3

### Methodology

The purpose of this research is to understand and explicate the experiences of collaboration in northern nursing practice, therefore, a phenomenological methodology using van Manen's (1997) approach was chosen for this research. Simply stated, phenomenology is the study and description of how a particular phenomenon as a lived experience is understood within an individual's subjective reality (Cohen & Omery, 1994; Draucker, 1999; Speziale, 2003). Van Manen (1997) states that people create their own meaning from their experiences or how they relate to the world, and in turn create their own reality within the context of those experiences (van Manen, 1997).

As a researcher, I am viewing reality as it is created by the participants' experiences, my own experiences, and the context (in this project, north of 60) in which these interactions take place. The interpretation of the participant's experiences with collaboration "...is understood to occur in context. Both the everyday experience of the subject and the researcher are participants in this context" (Cohen et al, 1994, p. 149). As the researcher, I am an active participant in the interpretive process of the lived experience and, if I am understanding reality as it is co-created with those I am interacting with, it is impossible to situate myself outside of the experience (Draucker, 1999). Therefore, my

presuppositions about the phenomena are brought to and become part of the research experience. Participants share their experiences and through the data analysis process I, as the researcher, incorporate my experiences into the interpretation but make every attempt to "...prevent the data from being prematurely categorized or 'pushed' into..." (Groenewald, 2004, p.16) my presuppositions about collaboration in northern nursing practice.

For example, one of the participants expressed her experience of collaboration as being mainly with her working relationships with physicians. As she was telling me of her experience, I was consciously aware that my experience with collaboration was of a more global nature. I realized that I understood collaboration to be about working with a wider range of people, including community members, not just collaborating with other health professionals. To ensure her perspective was incorporated and not filtered out completely through my own experiences, I asked her for an in-depth explanation as to the salience of the physician/nurse collaborative practice while at the same time incorporating my understanding of collaboration. Thus, the picture of collaboration that was constructed in my analysis incorporated the experiences of inter-professional collaboration as well as with community members. The broader view of collaboration was also supported by the experiences of other research participants.

Because my own presuppositions about the phenomenon are acknowledged as a part of the interpretive process, it is challenging to place my assumptions aside entirely. Nonetheless, by using research questions that are open-ended, allowing the interview process to flow by cue (Ray, 1994), I have attempted to allow the participants' experiences to drive the interpretive process. Also, by repetitive listening of the audio-taped interviews, I sought "...to become familiar with the words of the interviewee/informant in order to develop a holistic sense...which emphasizes the unique own [sic] experiences of research participants" (Groenewald, 2004, p.18).

### **Research Design**

Using a qualitative exploratory design, I explored the experience of nurses who are or have practiced in Canada's northern territories. Participants were registered nurses who have practiced in various communities throughout the territories with the population base of these communities being primarily First Nations people. These northern communities are the places of employment for these nurses where they gain the practice experiences that are of interest to the principal investigator. Although the nurses are working in First Nations' communities, the research did not deal with the direct delivery of health care to the First Nations' people, but with the experience of the nurses in that practice context.

### *Participant Selection*

As is consistent in phenomenological inquiry (Speziale, 2003), a purposeful sampling of the participants was used. Because of my own nursing practice experience in the NT, I have access to the names and contact information for some nurses who have worked in northern isolated and semi-isolated communities. I then telephoned the participants to solicit their participation (Appendix A for telephone script). I contacted eight of these nurses by telephone and requested their participation in the study. Additional potential participants were made known to me through a professional contact and I did seek permission to contact the potential participants through the social/professional contact person. I confirmed that the individual met the criteria for participation, and then explained the research project and questions involved, and ensured they understood the project and time commitment. I provided each participant with information regarding confidentiality and participation procedures (Appendix B for participant consent form).

Selected participants were registered nurses who are practicing or have practiced in a primarily Aboriginal community in the NT. To ensure that participants have sufficient experience with collaborative practice, only nurses who have at least five years of nursing experience in Canada's northern territorial setting were included in the study. Individuals being interviewed were

registered nurses ranging in age from 25 to 65 years. Education levels of these nurses varied from diploma nursing preparation with additional clinical and community health care courses to baccalaureate and masters preparation. All eight participants were in or have been in a Community Health Nurse (CHN) or Nurse in Charge (NIC) position in NT health centers.

### ***Data Collection***

Participants were interviewed in their respective residences in the NT and this site was mutually agreed upon by the participant and principal researcher prior to the interview session. The work place was not used as an interview site. Individual in-depth interview sessions were approximately 60 to 90 minutes in duration. With participant approval, sessions were audiotape recorded and then transcribed. The interviews focused on the participant's understanding of collaboration and how they use collaboration in their nursing practice. The interview format was semi-structured in which I asked general open-ended questions (Appendix C). Additional questions were asked depending on what was revealed during the interview. To encourage rich descriptions of collaborative work experiences from the participants, I asked probing questions to elicit greater detail when necessity arose. The consent form (Appendix B) outlined how the procedures and methods of the interview were described to the participants.

### *Data Analysis*

To understand and make meaning of the experiences of the nurses interviewed for this project, the data collected for this research was analyzed using van Manen's (1997) thematic analysis approach. Van Manen (1997) describes themes as "...the structures of experience. So when we analyze a phenomenon, we are trying to determine what the themes are, the experiential structures that make up that experience" (p.79). He defines wholistic, selective, and detailed reading as three reading approaches to construct themes in a lived-experience description source such as the transcribed interview used in this particular research. For the purpose of this analysis, all three approaches were utilized to aid me in developing an in-depth understanding of the essence of the lived experiences, as reflected in the transcribed interviews.

Using the wholistic (sometimes called the sententious) approach, the transcribed interview text was attended to as a whole to formulate a phrase that will summarize the elemental meaning of the transcribed experience. For example, in one interview the following phrase captured what I interpreted to be the participant's expressed experience:

"Understanding Aboriginal cultural practices are an important piece to collaboration in the delivery of health care in the north."

I then read the text several times selecting and highlighting statements or phrases that seemed to be necessary to describe the essence of the expressed experience. In this approach, I selected sentences or part- sentences in the interview that seemed to portray the participant's experience of culture and collaboration:

*"To understand that both parties need to work (together) to reach a common goal."*

This quote illustrates that the foundation of collaborative experience is the establishment of a relationship.

*"going through an interpreter may prevent some sort of misunderstanding"*

The nurse relies on interpreters for insight into cultural practices that may affect the health care being required (i.e.: emergent situation), provided (i.e.: support of a sprain), or inquired (i.e.: birth control methods).

*"To be absolutely sure that you know whatever they want to say is clear to you"*

It is essential that nurses in northern practice have fundamental understanding of how language is intertwined with the Aboriginal culture.

Finally, I reviewed each line in the transcription to determine if a sentence or sentence cluster revealed anything about the described experience.

Sentence 1: *To understand that both parties need to work (together) to reach a common goal.* This sentence demonstrates that collaboration is a process requiring participation of all involved in the provision of health care.

Sentence 2: *However, dealing with people going through an interpreter may prevent some sort of misunderstanding of different expressions.* This sentence demonstrates the necessity for nurses to have some education and understanding of the culture in which they are practicing.

Sentence 3: *To be absolutely sure that you know whatever they want to say is clear to you and...what you are saying is clear to them.* This sentence demonstrates how language and culture are salient in collaborative practice.

In the identification of essential themes, I was able to develop a narrative explicating the nurses' described experience of collaboration in northern nursing practice. I did return to participants for elaboration or clarification of their interviews. Because of the transient lifestyle of the participants, I was only able to confirm my interpretations of their interviews with four of them. Contact was initiated by the participants in the way of an invitation for me visit with them as they traveled through the community I was in. The discussions were brief and all the participants indicated they were content with my interpretation of their interviews.

### **Ethics and Politics of the Research**

My thesis committee reviewed the proposal for the study and an application for Ethical Review of Human Research was submitted and approved by the University of Victoria, Office of the Vice-President, Research, Human

Research Ethics Committee (see Appendix D). No risk to the participants in this research project was anticipated. The research provided an opportunity for participants to discuss their experiences and understanding of collaboration in their nursing practice. They were presented with an opportunity to discuss and reflect upon how collaboration affects their nursing practice in a way that builds on their current knowledge and insight into collaborative practice.

The interviews were not intended to cause any distress to the participants. However, because the participants discussed personal work experience, there was some chance that they would experience some emotional anxiety related to describing challenging work situations. Participants were informed prior to start of the interview that they could interrupt or terminate the interview process at any time should they experience any distress. The researcher had resource information available for the participants should they have requested or required support. No participant expressed or appeared to experience any distress in relation to the interview.

Because of my past work experience in the NT, I knew some of the research participants. Individuals were invited to participate in the research project and were informed verbally that participation was voluntary, and they should not take part in the research if they were reluctant to participate but felt obligated because of their relationship to me, the principal investigator. As well, I

informed them about voluntary participation in the body of the consent form, and told them that they could choose not to answer any given question, and that they could interrupt or terminate the process at any time without any consequences or explanation (Appendix B).

Names of participants did not appear in the audiotape transcriptions or in any other research related documentation other than the consent forms. All other identifying information, such as dates, specific time frames, and places, was removed from the transcribed data. Participants were not asked to reveal information about particular people; rather, they were asked only for descriptions of their experiences related to collaboration. Only the principal researcher had access to the raw data obtained and it was kept in a locked cabinet in the researcher's residence. My supervisor also had access to the transcribed interview data. Presentation of the data will only include quotes or examples not containing identifying information. A transcript of the participant's interview was available to them upon request and all participants declined a copy of their transcript.

No participants withdrew during the project. The collected data will only be used for the purposes of this research project. The audio taped interviews will be erased once the project is completed and the degree requirements are met. The transcribed interviews will be shredded after any articles for publication are

written, or after three years, whichever comes first. It is possible the researcher may also present the findings at a health care conference. A written summary of the results will be provided to the participants and a copy of the completed thesis will be made available upon a participant's request.

### *Trustworthiness*

The term "trustworthiness" was coined by Lincoln and Guba (1987) to refer to the criteria by which qualitative research is judged. They use the terms *credibility*, *transferability*, and *confirmability* for their criteria. *Credibility* refers to the extent to which the constructed realities of participants match with the realities represented by the researcher. *Credibility* was established in this study through the techniques of: a) prolonged engagement in the field; b) peer debriefing; and c) member checks (Lincoln & Guba, 1987). I have spent many years working in the north and have shared experiences in common with the participants, thus reflecting a prolonged engagement in the field. I have discussed the findings with peers and my thesis supervisor to ensure support for my interpretations, thus engaging in a peer debriefing process. Finally, I have conducted member checks by presenting my interpretations to some participants and they have confirmed that my interpretations reflect their experiences. However, nurses working in NT semi- and isolated communities tend to be transient. The transient nature of northern nurses limited my ability to get the

study material to participants for review. A verbal discussion regarding the interpretation of the interviews with 50% of the participants did occur, and these participants did concur with my interpretation.

Transferability refers to the extent to which the interpretations presented here are transferable to other settings and situations. Transferability is relative and depends on the similarity between the “sending and receiving contexts” (Guba and Lincoln, 1989; p. 24). That is, whether the findings are transferable to another setting depends on which salient conditions or characteristics match or overlap. The reader and not the researcher, based on the descriptions provided by the researcher, makes the judgment about transferability. Although a particular location (NT) was chosen for the data collection, the experiences described by the participants could be recognized by others in another location as being similar. For example, there may be some variability between Aboriginal cultures in the NT, yet the reader may see some similarities between their known situation and the experiences described by the participants in this project.

Confirmability was established through the use of memoing, which provides an audit trail during the analysis process. Using these memos, in conjunction with the interview transcriptions, another researcher would be able to follow the audit trail of decisions made throughout the research process and validate the decisions that were made (Creswell, 1994; Groenewald, 2004). As a

novice researcher, the memos I made are of a rather cryptic nature and another researcher may not be able to completely follow my decision-making process in this project. For example, in attempting to tease out the part education plays in collaborative practice, in a memo I listed several words that described what I interpreted to be key points made by the participants about education. I then reflected on the list and formed a statement that captured the essence of the listed words. Although I am able to understand the process I used in making decisions, the notes are not always written in a clear, concise fashion. However I would be able to walk a reviewer through the decision trail using my memos.

## Chapter 4

### Findings

#### Themes from the Data

The participants described the nature of collaboration in northern nursing practice as an ongoing process. Culture, relationships, and education are the three major themes within the experience of collaboration that were constructed from the collected data. The themes serve to illustrate aspects of the participants' experience of collaboration and provide some understanding of what that means for nurses in northern nursing practice. Within the three major themes, sub-themes were also identified. Even though the themes are discussed separately it must be kept in mind that they are not experienced in a linear fashion. Rather, they are intimately related to each other in an interactive way.

For example, a participant may describe an experience she/he had while working with an interpreter. Although this particular experience may be used to provide an understanding of the sub-theme communication within collaboration, it also reflects a reciprocal teaching/learning (informal education) experience in the interaction between interpreter and nurse. Language, as a sub-theme of culture, is also connected to the experience of working with an interpreter. Thus, the themes and sub-themes are integrally connected.

Quotations from the interviews will be used to assist in the describing the themes and sub-themes, and in turn give voice to the participants' experience.

### ***Participants' Experiences with Collaboration***

Health care in the north wouldn't exist without collaboration with all disciplines...all of the challenges when you think of providing service over this enormous geography with all of its isolation and climate issues and its infrastructure issues. I think that it's amazing what's accomplished in terms of health care of people and how well people really in some ways are taken care of, and that's all from people on the front line, be it telephone line or whatever, figuring out some way to collaborate. So in some ways it's remarkable up here.

The above quotation by one of the participants in this project demonstrates how collaboration is experienced and interwoven throughout health care and nursing practice in the north. In this chapter, themes (Table 1) generated from the collected data explicating the experience of collaboration by the participants will be presented in the following narrative.

**Table 1 Generated Themes**

Theme	Sub-Theme
The Centrality of Culture	Language Challenges
The Importance of Developing Relationships	Communication Conflict
The Nature and Adequacy of Education	Formal Education Informal Education

## Culture

The first of the three major themes is “Culture”. To collaborate (or to work with another or others) in reaching a common goal requires insight into how the other parties involved are constituted. Culture helps to shape who we are and how we comprehend the world around us. As reflected in the following quotation by a nurse, experiencing a new culture can feel quite overwhelming.

Everything was new, everything was different. You’re dealing in a different culture... Oh my god, you know.

Beliefs, values, how we perceive and understand our own reality are all part of the culture we come from and are familiar with and it takes time to feel comfortable in that new culture.

All I’m saying is that your culture and your language dictates that you perceive the world differently and you can’t appreciate it until you are comfortably within that world. I mean what I’m saying is that at a very basic level is that what you perceive depends who you are.

Nurses practicing in the NT are immersed in a predominately First Nations’ culture. Establishing and maintaining a collaborative practice in the NT necessitates that nurses are able to work with and in another culture that, more often than not, is very different from their own. The various communities throughout the territories share similar cultural characteristics and activities such as hide tanning, drying of meat and fish, drum dances, and spiritual values and beliefs. Several of the participants pointed out that one of most challenging

experiences with clients in collaborative practice was in understanding how cultural beliefs and values affect health care.

...some people can't hear information from the nurse because we may represent a foreign culture or an oppressive culture historically...how things are interpreted and how things are expressed and to try and always make sure people are understanding – it's tough because that doesn't always come through...

Only after nurses have worked in the context of the northern setting for a while do they come to comprehend the subtle ways in which culture impacts health and health care delivery. The experience of gaining insight in this context is described by one nurse in this manner:

I try to involve them (clients) a lot. Sometimes it's difficult because... I don't speak the language and there are some, you know, not problems out there, but some cultural things that some of the younger people won't do because... they said this is what our elders tell us and they're not going to cross that line.

In other words, how health care is viewed by some community members is very dependant on cultural values and beliefs. Elders in NT communities are often consulted on various matters (including health issues), and if what the Elder says doesn't coincide with the nurse's perspective or recommendations on an issue, it is highly likely that the advice of the Elder, rather than that of the nurse, will be the chosen path.

How cultural characteristics play out is different in each community, but the communitarian ethic is common. From a broader perspective, these northern

communities share traits with Aboriginal cultures across the North American continent such as the value that community needs supersede individual needs.

One nurse describes it this way:

Like the south tends to act towards the benefit of the individual, people tend to be very concerned about their individual rights and their individual responsibilities; whereas in a lot of northern communities the focus is on acting for the good of the community and if the individual has to be sacrificed for the sake of the community, out he goes.

Usually, nurses practicing in native communities are not Aboriginal and often their values and beliefs tend to reflect an individualist perspective rather than a collectivist perspective. Bringing this individualistic belief system into a setting that is community (collectivist) oriented means that nurses may find themselves disconnected from the community because they lack that cultural understanding of the importance of collective influence as it relates to health issues. One nurse describes her experience in this way:

You see that in particular with mental illness. When somebody goes snake in town they have to go out... they won't be allowed back unless they have been out for treatment and the community feels it's safe for them to come back. The community will act up and act up and act up until you send them out and then things calm down and that's kind of the dynamics. But you don't get that unless you sit back and look.

The nurse is saying that the means by which cultural influence is manifested can be missed unless a person has an awareness of what to "look" for. In this example, the cultural values and belief surrounding mental health issues are

made evident only when the nurse had insight into the community's inner workings. Over time the nurse comes to realize that knowledge and understanding of the local and broader Aboriginal culture plays a considerable role in a collaborative northern practice

How the nurse is able to respect the cultural ways of a community is dependant on her/his ability to develop a nursing practice that is collaborative and respectful of the First Nations' people in the community, and sometimes this can be challenging, as the following quotation suggests:

I'll just go back to the clients, there is the potential there for some miscommunication from the client to me or me to the client, I think, related to their cultural or ethnic background.

Another nurse has this perspective on what she thought was necessary in developing a collaborative practice within a First Nations' culture:

You need communication skills and you need some knowledge on cultural and ethnic backgrounds of people you are dealing with.

Practicing in the northern setting requires nurse to communicate effectively within the cultural setting of the Aboriginal communities and some nurses may not clearly understand the impact that their own cultural or ethnic backgrounds have on the development of collaborative practice. In learning about the culture and how to work within and with the community members it is essential that the nurse gain an understanding of how to communicate in that context. The nurse

can only do this by getting out there into the community and learning about the culture:

My feeling is that everybody has their culture and I like to share it with other people and like to learn from other people, that's my, you know, philosophy. Just learn day to day and be interested. Be open to different people, different experiences and learn from them. But culture as such...to me it is not something you study as such, it is something you learn. It is something you learn, you know by being outside (out and about in community) and talking to people.

Culture encompasses language; and whether that be a culture of a northern First Nations' community or a specific discipline such as nursing, the language spoken expresses the mores, customs, and history of that particular group of people.

Obviously we do not all speak or understand the same language. For example, the use of jargon such as "SOB (shortness of breath)" may be familiar and understood by nurses or health care workers, but may not be understood by the client. This creates a barrier or a challenge similar to the nurse's experience of trying to communicate clearly in collaborative practice in northern First Nations' communities in which English is the second language. To help the nurse in comprehending the culture of a community she/he must have some insight into how the language spoken will have an impact on the makeup of her/his collaborative practice.

## *Language*

Language is a sub-theme within the major theme of culture. It (language) is an integral part of all cultures and helps define and shape who we are within our world. The majority of nurses practicing in the north speak English as their first language while for many people in most NT communities English is often the second language spoken by community members. As much as language is a window to understanding one another, in the northern practice context it can also be a barrier. This is most eloquently stated by this nurse:

But what I realized is that people whose mother tongue is different from our own actually think in quite different ways and I think that that is basically closed to us...Because I think that language and thought patterns reinforce each other and that we stand outside of them. That I think is a huge barrier to communication...we're buried in our language and we are constrained by our languages. But because you're buried in your language it impairs you and you simply can't see that you are as boxed in as the other person who can't speak it.

To be effective in collaboration the nurse and client must be able to communicate and when the same language is not spoken a barrier is created. The nurse requires some awareness that, although English is spoken in a northern community, it does not necessarily mean that there is clear two-way communication, as noted in the quotation by one participant:

You very quickly learn that you are dealing with English as a second language all of the time, even with people who seem fluent in English.

Also influencing communication is the different dialect of English used north of 60 (personal communication Leslie Saxon, PhD. July 7, 2004). Thus, not only are nurses from the south challenged by the different languages spoken in the north, but they may also be challenged in trying to understand a dialect of English that is different than their own. In explaining this difference, Dr. Saxon presented the example of the word spill(ed), which is used in the north to mean a intentional act whereas in the south, to spill refers to an accidental act. In the south, if someone spilled water from a pitcher it would be interpreted as accidental. In the north, however, spilling water from a pitcher means to pour the water, an intentional act.

Although there are interpreters working with nurses, the understanding of different cultural expressions when dealing with people is always a challenge. Communicating via an interpreter is a learned skill, however, it is never without difficulties. One participant had this rhetorical question when she started practicing north of 60: "How do you speak through an interpreter?"

The nurse and the client rely heavily on the interpreter for clarity in communicating concepts necessary in the provision of health care. The interpreter is a powerful person in the relationship between client and nurse because interpreters have the ability to decide what information they want to

pass on to the nurse from the client and vice versa, as is made evident by the following:

I can talk to the interpreter and tell them what I want to ask the patient and she doesn't explain anything to the patient. And then I say to them, well aren't you going to tell them (and the response from the interpreter is) oh well, she doesn't need that or I don't want to ask her that.

Thus, in working with clients who do not speak English, nurses have very little control over what is communicated. Nurses often have to discuss difficult health issues such as a chronic or terminal diagnosis with clients. Although this type of discussion is not exclusive to northern nursing practice, it can have a bit of a twist when cultural and/or personal beliefs and values enter into the work of interpreter, client, and nurse. Because of the strong entanglement of language and culture in this setting, the interpreter has control over what is communicated between the nurse and client and vice versa. The nurse may think she/he is communicating effectively with a client but in reality this may not be the case. This could have serious implications for the client's future health and well being.

... I am a bit concerned as how my word is being translated to the patient and coming back how is it translated from the patient to the translator to myself...asked the translator to talk to a patient about cancer yet there was some hiccup with the translator. Either they were related to the client or because of some cultural bias there the translator did not use the cancer word so in actual fact the client didn't find out they had cancer.

A nurse who is not familiar with the culture and has not yet been integrated into the community often feels that she can do very little in such circumstances.

A piece of collaborative practice is the necessity of working, not only with the client but also with the clients' family. For example, in many situations the client's immediate and extended family is as much involved in the client's care as the nurse, particularly in facilitating communication. Within this context, the nurse is communicating via interpreter and others simultaneously all the while trying to deliver competent nursing care.

Well, again you have to be very cognizant of people's language abilities but not just in terms of English as a second language but literacy level as well. And be willing to try and advocate for them to either have interpreters or if they really aren't understanding to try and find the best person to maybe help the communication process...

Through the communication process, relationships between the nurse, community members, and colleagues can be developed and solid relationships are a key factor to collaborative practice. These relationships are central to addressing the kinds of dilemmas discussed above.

### **Relationships**

"Relationships" is the second major theme within the participants' experience of collaboration in northern nursing practice. Participants articulated that relationship development in collaborative northern nursing practice was essential for true collaboration to occur. The development of relationships took

place between the nurse and her/his colleagues, with clients, and with members of other disciplines both in and out of the health care arena. Without the establishment of relationships to help them understand and work within the contextual setting of the north, nurses indicated they would be extremely limited in their ability to practice. They identified that relationships provided the valuable catalyst required to gain insight and understanding into the Aboriginal culture and a sense of the community in which they were practicing, and how that community worked. Yet, this takes time to develop. One nurse explains it this way:

It takes awhile to learn the nuances and just the different power structures and where your power is and how families work and how politics work up here. It's not as clear cut as you would think.

The nurses interviewed for this project expressed the challenges of forming relationships within the context in which they lived and worked. Nurses indicated that the establishment of relationships was a complex, sometimes convoluted process that involved an intricate "give and take".

...you need to establish solid working relationships with people in your community...people in the south tend to think of collaboration in terms of doctor-nurse relationships and agency relationships, like formal referral processes, but in the north it is that and a whole lot more. Like you are constantly being asked to perform outside your boundaries. If you want your skidoo fixed you have to provide vet services for the mechanic's dog.

They explained that these interactions influenced their day-to-day practice and added quality to the relationships formed with community members. Often these relationships extended beyond the work place in significant ways, making evident that collaboration is essential for even the simplest things to occur. One nurse, for example, explains the relationships in this way:

I think in the north you have to work with so many different people. If you want water for the health center you had better be getting along with the hamlet senior administration officer. If you want your garbage picked up, any of those things, things that people take for granted in the south, require collaborative effort in the north.

In building relationships nurses explained that they needed an understanding of the roles people had in the health center, in the community, and how disciplines or agencies were involved in the in community in order to collaborate effectively. This understanding contributed to the knowledge of how “things worked” in the community. If you don’t know how things work, you don’t know when to consult or collaborate, or with whom. As one nurse said:

...I think that it is important that one somehow has a good idea what these people do, and preferably I like meeting these people so they can explain to me exactly what they are doing and how they are involved within the community... Once I think I know exactly what their domain is, it becomes much easier to identify when you should consult them about ...(whether it be) family members...the janitor who may do some interpreting for you, to the clerk booking appointments, to the CHR (community health representative), to other nurses, to... someone at the hamlet or health and social services.

In establishing and maintaining relationships within the context of northern collaborative practice, nurses expressed frustration with the way some things are done in the northern isolated or semi- isolated setting. They discovered that their southern-based nursing experience and definition of normalcy did not translate well to the northern setting. At times, knowing what to do and who to contact in a situation could feel overwhelming. The outcome often depends on the understanding and relationships the nurse has with community members. One nurse describes the experience in this way:

There are all kinds of things that are way beyond normal - picking up 911 and calling an ambulance...A classic example – who is the ambulance driver this week, you know, because they change weekly. Which service is providing it? You know, is it the co-op or is it the northern store that is using their truck as the ambulance? Who has the contract this week? Where are the staff because ... it's something they do that they don't realize necessarily, how do I say this nicely, that they're ambulance drivers, for want of a better word, is a glorified taxi service , have all been on a bender and everybody is hung over, who do you get to go pick up the medevac team and when these services don't work, who do you call?

Relationships are a process and take time to develop. Time is required for nurses and community members alike to become familiar with each other so that together they can work toward providing the optimum health care for that community. The learning process is mutual, which facilitates relationship development and paves the way for collaboration, as this nurse explains:

You are working with people in the community. You need to know how they feel about nursing. How they feel about their care, like

how do you involve them with their care. So you collaborate with them on their level and they help you out as well. They tell you what their practices (traditional medicine) were, and you try and actually bring those practices into your work that you are doing and that's collaborating with the community...

Because of the geographic isolation, the close proximity of living accommodations (not only to the health center, but also to each other), and working conditions such as 24 hour call, the need for solid communication skills in relationships with nursing colleagues and others was described as being significant, and very different than anything they experienced in the south. Thus, communication is the first sub-theme within the relationship theme.

### *Communication*

Communication is an integral part of building relationships and is viewed as being multi-faceted by the participants in this project. Although communication is central to building relationships irrespective of location, in the provision of health care services in the north, the nature of communication can become quite complex in relation to coordinating all aspects of health care.

Information gathering and exchange is part of communication and is not a linear process. Resources used for the purpose of information gathering that are familiar to the nurse working south of the 60<sup>th</sup> parallel present quite differently in the northern context. For example, nurses in the north have quite a different relationship with support staff than in the south. Local people fill the support

staff roles of receptionists, clerk interpreters, pharmacy clerks, TB and diabetes program workers, community health representatives, home and long term care workers, janitorial and maintenance, ambulance attendants, and x-ray assistants. Support staff are an essential resource to the nurse, and often play a more direct role in providing health care than they do elsewhere. The communication and thus collaboration with these people is central to the provision of essential care, as illustrated by the following comment by a nurse:

... with support staff all the time... they obviously provide translation services, they provide tremendous background on who people are and what their social setting is, so for instance when you... have a TB case and you need to do contact tracing, it's the support staff that put together all the puzzles of who lives in what household and who's related and who's adopted and who you know sleeps at this house and – it's so that you're able to do a complete circle of contract tracing - that kind of work wouldn't exist ...

She is saying that, compared to the support staff, the nurses have a very small circle of contacts and would be quite limited in their ability to have community members collaborate with them in contact tracing of a communicable disease. Often the people who are being traced for treatment of a communicable disease such as TB go into hiding. That is, they will move from house to house, or community to community, and the community network system is the best and sometimes only way of finding individuals so they can be treated and the community protected. It is this community network that support staff have the

access to, thus providing the nurses with a valuable resource. If support staff members do not have a comfortable trusting relationship with the nurse, the information the nurse requires becomes unavailable or exceptionally difficult to obtain, thus putting the community at risk. Their importance can therefore not be underestimated. Support staff also have an “insider” cultural perspective on how to approach community members to help achieve a working relationship between the nurse and any particular individual.

Another nurse provided this example of the complexity and necessity of communication with health center support staff in her collaborative practice:

...a lot of the information we sometimes get is word on the street information (that) comes from support staff. Support staff would sometimes come in and oh, I don't know if you know this but so and so is back in town, and so and so might be a schizophrenic who needs meds who you thought was at a group home...and they will quite often give you a heads up to follow things up.

It is evident that nurses in northern practice must depend, not only on their own skill and ability to communicate, but also on the communication abilities of co-workers. Learning to trust in the process of working with support staff helps to create a communication resource that is vital in northern practice.

Clarity in communication is also very important in northern practice in relation to emergency situations. The nurse is often the sole health care provider in these situations and often needs to consult with a physician. In the north, this consultation usually takes place over the telephone with a physician in the

emergency room of a hospital that is several hundred kilometres away from her community. One nurse sums up the importance of communication clarity in that type of situation by saying:

Well, I think it's key...you need to be very clear yourself about what you are communicating, and that comes down to making sure that again you've got sort of all your ducks in a row...that you've got your information and it's very well researched, logically presented.

Often the emergency room physician is doing a locum position and therefore has little or no idea as to the set up of health centers in the community. The absence of face-to-face communication complicates the situation:

...you may be calling one hospital to ask for the plane and another hospital to admit...you never really get to see face to face many of the people that you are asking for help, I'm referring to the staff in the emergency at the hospital that you refer to or the visiting physician that may be up there for three weeks. ...it is three in the morning, he has no idea who you are and you are asking for a 30 thousand dollar medevac...

In such an emergency situation, much is at stake, and a successful outcome is dependent on the nurse's ability to communicate clearly, succinctly, and quickly what she needs to deal with the client's health needs.

As in the south, technology plays an important role in communication between individuals and the organizations in which they work. E-mail, faxes, and the telephone are just some examples of the taken for granted methods of communication we have all become accustomed to and somewhat dependent on

in the functioning of our personal and daily work lives. The nurse practicing in the north learns not to take something as common as the telephone for granted because the technology available to her/him in the northern communities creates some frustrating situations, as noted by the nurse in the following quotation:

Your phone lines are always a challenge, you are dealing with satellite communications and they have delays, and glitches and beeps and weird and wonderful things that happen and you are trying to articulate something over the phone through a communication barrier of an infrastructure nature...

In northern practice nurses often deal with emergencies arising from incidents that happen to community members while they are out on the land and the only form of communication available to the nurse is via bush radio. Communication in situations like this present special challenges for all parties involved, and the nurse is stretched in terms of how she uses and disperses the information provided to her. One nurse explains this quite clearly:

It's creative but you know, it's just trying to figure out where people are. A lot of the traditional hunting sites don't have proper place names on a map. They don't carry GPS (global positioning systems). They know where they are but try sending a helicopter out there. And then you have to communicate that kind of information to a pilot. What kind of supplies do you need to take out? What kind of vehicle can you send? Can you send helicopter? Is there somewhere for it to land? Do you have to send a plane? Is the ice stable enough for them to land? Are they stuck there till whenever? Do you have to get the military involved for search and rescue? There are all kinds of things that are way beyond normal picking up 911 and calling an ambulance.

In overcoming communication challenges within a collaborative practice, northern nurses learn how to trust and respect their co-workers' skills and abilities. Whether it is a nurse on a medevac team or a hunter out on the land, the need for clear communication with one another should never be undervalued.

Failing to appreciate the necessity of clear communication in the northern practice setting can lead to the creation of tension or conflict in relationship situations. The phrase in the previous quotation "kinds of things way beyond normal" is reflective of many situations the nurse experiences in northern practice. Even conflict situations are experienced in ways that are "way beyond normal."

### *Conflict*

Conflict is the second sub-theme within the major theme of "relationships." In many life interactions, conflict is part and parcel of the communication process. In describing their experiences with conflict in the northern collaborative practice context, participants indicated there were several factors that contributed to situations of conflict that were unfamiliar to them in the south. Factors included the transience of northern nurses, and working and living conditions beyond their known norm. However, participants perceived that conflict situations were primarily related to the close proximity to co-workers in living and working relationships. Most situations in the north dictate

that not only do nurses work together, they must often share the same living space. One nurse provides this example:

In the north you quite often wind up living with your colleagues which is not something that happens down south. I mean where else would you get to live, work, eat, sleep, and stay inside in 40 below weather for like 10 months of the year in a health center that has three bedrooms, a shared bathroom, shared kitchen and a shared living room off your emergency department. It's not just collaboration. I mean, if you can come out of that not killing each other you're doing well, you know.

This nurse expresses similar sentiments:

...you're living in transient accommodation, you quite often have to share with people you have never met before, and you're sharing a bathroom, a kitchen, and a living room and it's not even like a college dorm situation. At least in college you go to separate classes. Here, we go to the same work place and its um...

This "in-your-face" proximity to each other is not uncommon in the northern setting and often lends itself to conflict situations in and out of the work place.

Conflict in working and living relationships can affect collaboration.

I think that sometimes I know I've held back from addressing things maybe as honestly as I should in a work place setting because the reality is this is the only other nurse and sometimes the only other support socially and also in the middle of the night... there may be some conflict with this nurse over a certain issue at work and you might address it, but I think in some ways you do it a bit more carefully sometimes because you also know that at 3 in the morning I have to call this nurse and depend on her or him.

Nurses practicing in the north tend to be a fairly transient population and with this transient nature comes a wide variety of personalities. The employment

positions available in the north outnumber the qualified nurses required to establish a stable workforce in many health centers. This creates situations of casual or term employment that is attractive to many nurses in that they can travel to different communities and have a set time in an isolated setting that makes the isolation more tolerable. These term positions can be anywhere from weeks to months in length thus causing the nurse staffing in health centers to be short term with high turnover. Thus, in addition to the increased number of nurses moving through a health center is the added complexity introduced by the individual personalities each nurse brings to the setting. Nurses are therefore continually dealing with the "newness" of colleagues both in the work and home environment. This increases stress in the work setting.

Because we live together and we are (always) with each other, work together and there is nowhere else that asks that of you. So I can think of lots of conflict situations you know again because of this tremendous turn over and tremendous personalities drifting in and out.

Because of the inevitability of conflict in northern practice, for all of the reasons cited above, conflict resolution is absolutely necessary. Without it, life can be very difficult for these nurses, as the following quotation illustrates:

If you are in a two nurse station and you're not getting along with that other person 50% of your life just got miserable.

Communication between the nursing staff becomes vital. Although conflict may be recognized, because of the isolation and dependency on each other, conflict is

“resolved or dealt with” often by accepting each other’s quirks. Nurses see this as necessary for survival in the job.

...the majority of conflict that I can think of in terms of situations conflict...because that’s who we are working with at the time, and other disciplines tend to more geographically removed and our contact with them is usually over phone or very brief. So the majority of conflict tends to be with us nurses in these settings. That’s not surprising cause it’s a bit of a warped environment; because it asks you to work with people and to live with (the same) people. I think it makes you want to avoid conflict a little more maybe. So I think that it makes you deal with conflict a little bit differently than you may in another setting.

Clearly, conflict is not always addressed directly because of the circumstances and working conditions in the north. At the same time, the need to “forgive” idiosyncrasies and to recognize and appreciate each other’s strengths may well be a positive feature of nursing relationships that one does not find as much in southern practice. Cooperation is essential, and the ability to both tolerate and value a colleague’s strengths makes collaboration in practice that much more effective. This is reflected in the following quotation:

I think it’s because you work with a huge variety of different nurses in northern settings most of whom are coming and going. There’s not a lot of permanent, so I think you have to be quite forgiving of a lot of the personality traits and you have to be very good at recognizing where people’s strengths are because everybody has strengths in different areas.

Conflict is both inevitable and widespread in collegial relationships among nurses in the north, largely due to the working and living conditions. Isolation,

transience, lack of stability in the workforce, and the constant requirement to “break in” new staff contribute to the experience of conflict. At the same time, the challenging living and working conditions contribute to nurses developing a tolerance for, even appreciation of, other’s characteristics and strengths that may not be found in southern nursing practice.

### **Education**

“Education” is the third major theme constructed from the data. Within the process of collaboration, education is salient. Whether information is obtained via a formal or informal route, the process of teaching/learning (education) provides the knowledge needed for nurses to recognize and understand the complexities of collaboration in northern practice. A particular type of education is necessary.

A commonality among nurses practicing in the north is they all have the basic education required for entry into nursing practice. The foundation for the fundamentals of nursing practice is laid down with academic education in areas such as assessment skills, diagnostic skills, basic communication, and critical thinking.

Nurses arrive in the northern setting prepared with a formal education from a college or university usually attained in mainstream institutions located in the south and staffed, for the most part, by faculty who have had no

experience with northern nursing practice. As the nurses spend time in their northern practice, they often arrive at the realization that their education and experience in the south has not provided them with the knowledge and skills they need to practice effectively and collaboratively in the north. One nurse explained it this way:

When I first came up north... nothing in that skill set... translated with the exception of some of the palliative care stuff, cause that was a good skill to translate to the community, but there was really nothing that translated into a northern skill set...

Although nurses have a “higher” level of education (post-secondary preparation such as baccalaureate degree) than most members of the community in which they work, they often lack the community and cultural knowledge so necessary to health care in the Aboriginal communities. To collaborate within the northern context, the nurse has to have some form of education to understand and be able to function within that environment. It is this process of collaboration with those in her/his work/community environment that provides the nurses with some of the “grass roots” knowledge necessary to provide and work with Aboriginal people in the health care arena.

Informal and formal education are two types of education that nurses talked about within the major education theme. As the nurse establishes a collaborative practice in the northern setting, she or he is learning about many things related to practice in a very informal way that could only be learned about

within the practice/community context. The nurse also brings to her/his practice, the knowledge gained through formal education.

### *Formal Education*

Formal education includes the preparation (diploma, baccalaureate, masters, or doctorate) that a nurse attains at a post-secondary education facility such as a college or university. Formal education provides the credibility with public and colleagues that is necessary for collaboration with others. Nurses come from varied educational backgrounds and one nurse expressed her views about the contribution of her education to collaborative nursing practice in this way:

...you have to collaborate in this setting in a very global way..... there's always these challenges of culture and language and so you have to have a really broad base – kind of a generalist – my arts education in fact has contributed more than my nursing education and background to my success in the north. And I think it's that ability to maybe see the big picture sometimes and to see that maybe there's different points of view in terms of how to look at problems or may explore problems and go oh, okay we missed the boat there, we obviously didn't get that or what's happening here and to kind of be able to put things into a bigger scale.

An important element of what this nurse is saying is that the formal education she obtained with her arts degree contributed to her global perspective of collaborative practice. The arts education supports her nursing knowledge and helps to create the ability to have a greater worldview of collaboration in northern nursing practice. This raises important questions whether sufficient

non-nursing courses are incorporated into nursing programs that would help nurses to develop a more global perspective.

The participants interviewed recognized that their formal education did not end once they graduated from their respective post-secondary educational institution. Although not exclusive to northern nursing practice, certificate courses such as midwifery, advanced critical care, Advanced Cardiac Life Support (ACLS), and Basic Trauma Life Support (BTLS) are recognized as being an important component in competent northern nursing practice. Programs such as the Introduction to Nurse Practitioner (INP) in the NT (offered at Aurora College) for example, are viewed by nurses as necessary for them to be competent in their northern nursing practice. Courses within the program address advanced assessment and diagnostic skills, task oriented skills such as x-ray taking, suturing, and laboratory work. Although similar to some nurse practitioner programs in the south, this program includes a cultural component to enhance the nurse's awareness of the Aboriginal cultures that exist in the NT

As one nurse states:

...courses which were always very practical, always were focused on work in northern health centers.

Programs and course, such as the ones described, build on the fundamentals of nursing practice that begin with formal education. This education provides a solid foundation from which to establish and maintain a collaborative practice.

### ***Informal Education***

Nurses working in the north also learn in an informal way, in part by actually collaborating as well as by sharing information and the knowledge about collaborative practice that each individual has gained through their own experience and education. Varied life experiences, knowledge, and education are brought to the practice setting by the nurse and those with whom she/he interacts. In this interaction, teaching and learning is shared informally within the context of the nurse's practice. As one nurse explains:

...without a doubt the reason that I've survived in this environment is because of other nurses in collaborating with them and drawing on their experience...

Another nurse has this perspective:

A lot of times it's (others' experience and the knowledge gained) told anecdotally as a joke or things over dinner but I think there's a big learning process that goes on with that in terms of I guess that's more learning rather than – but it's also collaboration.

The discussion that takes place between and among nurses and others is an informal means of education in which knowledge and information from other disciplines, from people in the community, and from other sources is brought into collaborative practice. Access to experiential knowledge, including knowledge related to collaboration itself, was described by participants as being integral to the complex practice of northern nursing. Seeking out the experiences of colleagues contributes to the process of collaboration by the sharing of

information, the exchange of ideas, and the creation of a work environment in which the goal is to provide the best possible health care for individuals and the community at large. One nurse describes this “seeking out” in this way:

Well, this nurse is particularly strong here and that’s the nurse I should try and seek out in this area, or go to for advice and lot of it is discussion about what’s happening with cases or looking at things a different way, and I think also listening to their experiences from other places you end up learning a lot...I feel it’s touching base with and bringing in the knowledge that those people (other disciplines and nursing colleagues) have that impact on my role at the time.

### **Summary**

The importance of collaboration in northern nursing practice was the overarching theme of this study. Because of the isolation and vast distances between communities, face-to-face interaction by the nurse with many of those with whom she or he is collaborating is rare. In developing and maintaining a collaborative practice, nurses in the northern setting more often than not have to develop relationships from a distance with other disciplines, organizations, and the general public. The starting point of building these relationships may be unfamiliar to many nurses because of the variety of working relationships necessary for survival in the north. For example, many nurses may never have been exposed to working with an interpreter on a daily basis prior to their arrival in the north. Thus, the nature of collaboration is very different than collaborative practice in the south.

Collaboration in the north is influenced at multiple levels with each level being distinctive in and of itself. That is, the nature of collaboration is conditional upon the characteristics of the community, the people of the community, the relationships that the nurse establishes within and external to the community including relationships with colleagues and support staff, as well as the education and experience the nurse brings with her or him.

In summary, within the process of collaboration, three considerations are essential for effective collaboration to occur in northern practice. First, knowledge about and understanding of the northern culture is central to collaborative northern nursing practice and plays an important role in the delivery of health care by northern nurses and those with whom they work. Understanding how cultural nuances and the language affect the way in which health and health care is perceived in northern communities will have an effect on the manner in which collaborative practice takes place. Thus, cultural competence is essential for the advanced practice nurse in northern practice.

In addition to developing an understanding of the culture, the northern nurse must also build a set of relationships with a much broader range of collaborators than nurses who work in the south. The quality of the relationships will determine the effectiveness of the collaboration that is so necessary in the north for the provision of primary health care.

Finally, the nature and quality of the collaborative practice established by the nurse in the north will depend on the types of educational experiences she or he has had. These include both formal and informal. Currently, formal education is limited in providing nurses what they need to know to practice effectively in the north. The deficits in knowledge and skill relate primarily to the nature of collaborative practice and the role of culture. It is the knowledge and skill gained through experience that provides these nurses with the competencies to practice effectively.

## Chapter 5

### Discussion

#### Cultural Theory

By sharing their experiences about collaboration in northern nursing practice, the nurses who participated in this project demonstrated the complexity of collaboration in the context of nursing north of the 60<sup>th</sup> parallel, and that the culture, relationship development, and education of nurses and members of the northern community in which practice are very much interwoven. These findings are consistent with Leininger's "... Theory of Culture Care Diversity and Universality, which is based on the belief that people of different cultures can inform and are capable of guiding professionals to receive the kind of care they desire or need from others" (Welch, Sr. A. Z., Alexander, J. E., Beagle, J., Butler, P., Dougherty, et al., 1998, p.444).

To illustrate her theory, Leininger developed the Sunrise Model that depicts individuals as inseparable from their culture. In this model, components of social structure and a worldview influence core health beliefs through language, ethnohistory, and the environmental context (Welch, A. Z. et. al.; 1998). Technological factors, religious and philosophical factors, kinship and social factors, cultural values and lifeways, political and legal factors, economic factors, and educational factors are depicted in this model as being influential in health

care provision at the grass roots (communities) level and professional (nursing practice) Welch, A.Z. et. al.; 1998). All of these factors are present in the major and sub themes discussed in the findings chapter of this thesis and are consistent with Leininger's work. For example, within the sub theme of communication, the technological challenges of the phone and computer system as described by the participants is a factor affecting how health care is delivered and received in northern communities. The cultural values and lifeways factor in Leininger's model is evidenced throughout the major theme of centrality of culture as the participants share their experiences of how health and health care in northern First Nations communities is perceived and understood by nurses and members of a particular community.

### **Implications for Nursing**

As stated by Stapleton (1998), "communication is the essence of collaboration. Without effective communication, it is impossible to develop the relationships required for collaborative practice" (p.13). Because language and the manner of communication is so intertwined with Aboriginal culture, nurses, interpreters, clients, and community members alter their style of communication to better understand each other's perspective for the purpose of establishing an effective communication level for all involved (Stapleton, 1998). The understanding gained through the process of sharing and cooperation in

communication leads to the relationship development required for collaborative practice to evolve (Stapleton, 1998).

The isolation and geographical distances from the nurse's familiar environment and also between NT communities adds to the sense of being a foreigner in your own country. Collaborative practice in this environment requires a willingness for the nurse to learn about the culture by interacting with community members, respecting that First Nations' values and beliefs may be different than their own, and being prepared to discuss those differences and similarities openly with community members and colleagues alike (Carberry, 1998, Stapleton, 1998). Collaboration involves not only knowing and learning about the culture of the northern practice setting, but also understanding the practices of and working closely with other disciplines such as social workers, RCMP, physicians, and teachers. Stapleton (1998, p.15) suggests that nurses in a collaborative practice recognize that "a clear understanding of each discipline's scope of practice on the part of all team members, including the client" demonstrates professional maturity, insight into the contributions and limitations of respective disciplines (including nursing), and the acceptance of other practices (Stapleton, 1998).

In the north, collaboration has a different significance, meaning, and impact than collaboration in the south because of the physical, familial, and

spiritual ties between people and their respective communities. The nurse is often considered an outsider in the northern setting due to her or his lack of understanding the language, community nuances, who's who in the political scene (i.e., the local band Chief, the Grand Chief, the hierarchical relationships of families in local, regional, and territorial politics), and how those factors interact to affect the nurse's ability to establish and maintain collaborative practice.

Although these factors are present in some southern provincial communities, they can become a daily challenge and at times quite problematic to northern collaborative practice. For example, it is highly unlikely that a politician in the south would phone an emergency service demanding that an ambulance be dispatched because one of the politician's relatives has phoned and requested that service, despite being informed by emergency health personnel that that level of service is not required. However, in many northern communities nurses have received phone calls in the middle of the night from authority figures such as MLAs, Chiefs, or mayors telling the nurse to carry out a land or air medevac procedure based on the request of a relative. Nurses have been told that the authority figure knows best and the nurse's knowledge of the situation is discounted. The appropriate management of such a situation is often beyond the experience and skill set of the nurse.

### **Implications for Policy**

Being able to work with and in the context of a northern Aboriginal community requires that the nurse learn from the community members, because if the nurse cannot do this, there will be no cultural interpreter for them and who else will be there to teach them? Educators and policy makers need to listen to the health care providers who have experienced or have practiced in the northern context themselves. The educators and policy makers can understand the verbal expression but can't truly "feel" or understand the cultural customs, beliefs, and values that contribute to collaborative practice with First Nations' people.

In the CNA competency framework for advanced nursing practice, the concept of culture is not explicitly incorporated into the key elements of ANP. Although this research focused only on the collaborative competency of the framework, the centrality of culture would apply to the clinical, research, leadership, and change agent competencies as well. It would be difficult, if not impossible, for the nurse to exclude the influence of culture in the delivery of health care in all areas of competent nursing practice at the advanced level. For example, in addressing the clinical health concerns of an Elder client in a northern community, the nurse would have to have an in-depth understanding

of the importance of the language and the values attached to how the interpreter must communicate the needs of the nurse without offending the client.

Taking on a leadership role in the northern context would have a different meaning than a leadership role in the south. For example, in the north the leadership role in developing health policy often involves Chiefs from more than one community, consultation with Elders, and feedback from community members who are high in the hierarchical family power structure of a particular community.

The ability to “clue in” and recognize where the nurse fits into this context necessitates an understanding of the culture and cultural influences on the delivery of health care programs in every area of nursing practice. To address the absence of cultural consideration in the key elements of the CNA, the definition and characteristics of ANP could include that cultural influences be taken into account in the assessment and treatment of clients. Although this study focused on northern practice and the centrality of culture in collaboration, it seems that cultural considerations would be important whatever the setting of practice. Thus, it seems that the absence of culture from the key characteristics of advanced practice is an oversight that could be readily addressed with the addition of a single statement on the importance of considering culture in the provision of nursing care by advanced practice nurses.

## **Implications for Research**

“Working together” in northern practice may take on a significance foreign to many nurses when they have to do an assessment on an ill person via bush radio, be a liaison between airport personnel and staff at a distant receiving facility, and at the same time ensure family members are kept updated on the process. Taking into account the geography of the territories and the isolated conditions in which northern nursing practice is situated, collaboration becomes an intricate and essential process in facilitating the nurses’ work. The nature of that collaboration is significant in northern practice, and little in the formal education programs provide the knowledge and skills that nurses need to collaborate effectively in practice. Much of what they need to know is learned informally within the context of their practice as they become immersed in the cultural setting of the north, learn about that culture, the language, develop a set of communication skills, and establish relationships with colleagues, other professionals and community members.

## **Conclusion**

What makes collaborative practice north of the 60<sup>th</sup> parallel distinctive from that in southern Canada is the total immersion into First Nation’s culture, language, beliefs, and values. Nurses practicing in this setting must understand that Aboriginal culture and language is salient to collaboration in the delivery of

health care in the north. Culture and language shape individuals and bring an understanding to the world or reality in which they live. In the north, nurses work with and in predominately First Nations' communities and because they often are not "of" that northern world discover that the necessity of learning about the First Nations' culture is key to collaborative practice.

## REFERENCES

- Aboriginal Health Unit, Alberta Health (n.d.). *Strengthening the circle*. Edmonton, Alberta: Ministry of Health.
- Advanced nursing practice: a national framework* (2000). Canadian Nurses Association: Ottawa.
- Allen, I. (1993). Aboriginal people living in remote and northern areas. *The path to healing: report of the national round table on aboriginal health and social issues*. (pp.130-138).
- Artz, S. (1993). Feeling as way of knowing. *Journal of Child and Youth Care* 8(4), 1-11.
- Bevis, E.M., Watson, J. (1989). *Toward a caring curriculum: A new pedagogy for nursing*. New York: National League for Nursing.
- Caelli, K., Ray, L. & Mill, J. (2003). 'Clear as mud': toward greater clarity in generic qualitative research. *International Journal of Qualitative Methods*, 2(2). Article 1. 1-24.
- Campbell, M.L. & Jackson, N.S. (1992). Learning to nurse: plans, accounts, and action. *Qualitative Health Research*, 2(4), 475-496.
- Campbell, M.L. (1992). Nurses' professionalism in Canada: a labour process analysis. *The International Journal of Health Services*, 22(4), 751-765.
- Campbell, M.L. (1996). *Institutional Ethnography and Questions About Experience as Data*. Paper presented at the 13th Qualitative Analysis Conference "Studying Social Life Ethnographically", McMaster University May 28-31, 1996.
- Campbell, M.L., Daramola, O.I., & Dorris, G.A. (1995). An advanced practice model: inpatient collaborative practices. *Clinical Nurse Specialist*, 9(3). 175-179.
- Canitz, B. (1990). Nursing in the north: challenge and isolation. In Crnkovich, M. (Ed.). *"Gossip" a spoken history of women in the north*. (pp. 193-212). Ottawa: M.O.M. Printing.

- Carberry, C. (1998). Contesting competency: cultural safety in advance nursing practice. *Collegian*, 5 (4). 9-13.
- Chapman, I., McCaskill, D., Newhouse, D. (1991). Management in contemporary Aboriginal organizations. *Canadian Journal of Native Studies*, 11(2). 339-349.
- Collins Concise Dictionary*. (Revised 3<sup>rd</sup> ed.) (1995). Glasgow, Great Britain: Harper Collins Publishers.
- Community Health Nursing* (Proposal submitted to the Peer Review Committee of First Nations and Inuit Health Programs Directorate, Medical Services Branch Health Canada). Victoria, B.C.: The School of Nursing University of Victoria. (November 1997).
- Continuing competence: self-assessment and planned learning workbook for registered nurses* (1998). Registered Nurses Association of British Columbia: Vancouver.
- Creswell, J. W. (1994). *Qualitative inquiry and research design: Choosing among five traditions*. Thousand Oaks, California: Sage Publications.
- Creswell, J.W. (1994). *Research design: Qualitative and quantitative approaches*. Thousand Oaks, California: Sage Publications.
- Daly, K. (1997). Re-placing theory in ethnography: A postmodern view. *Qualitative Inquiry*, 3(3), 343-365.
- Davies, B. & Hughes, A.M. (1995). Clarification of advance nursing practice: Characteristics and competencies. *Clinical Nurse Specialist*, 9(3). 156-160.
- Dechairo-Marino, A.E, Jordan-Marsh, M., Traiger, G., & Saulo, M. (2001). Nurse/physician collaboration action research and the lessons learned. *Journal of Nursing Administration*, 31(5). 223-232.
- Di Marco, M.M., Storch, J. L. (1995). History of the Canadian health care system. In Wilson, D.M. (Ed.). *The Canadian health care system*. (pp. 5-15). Canada.
- Dreher, M. & MacNaughton, N. (2002). Cultural competence in nursing: foundation or fallacy? *Nursing Outlook* 50(5), 181-186.

- Draucker, C.B. (1999). The critique of Heideggerian hermeneutical nursing research. *Journal of Advanced Nursing*, 30(2), Retrieved June 18, 2003 from <http://80-web13.epnet.com.ezproxy.library.uvic.ca/citation.asp>
- Favel-King, A. (1993). The treaty right to health. *The path to healing: Report of the national round table on aboriginal health and social issues*. (pp.120-129). Ottawa: Canada Communication Group.
- Fisher, B. & Tronto, J. (1990). Toward a feminist theory of caring. In E.K. Abel & M.K. Nelson (Eds.), *From circles of care: Work in identity in women's lives* (pp.35-61). State University, Albany, N.Y.: New York Press.
- Fleming, V. (2003). Hermeneutic research in nursing: developing a Gadamerian-based research method. *Nursing Inquiry*, 10(2). 113-120.
- Gardner, D.B. & Cary, A. (1999). Collaboration, conflict, and power: Lessons for case managers. *Family Community Health*, 22(3). 64-77.
- Goodwill, J. C. (1992). Organized political action by a group: Indian and Inuit nurses of Canada. In Baumgart, A. J. & Larsen, J. (Eds.). *Canadian nursing faces the future* (2<sup>nd</sup> ed.). Toronto: Mosby-Year Book, Inc.
- Graham, K. (1994). Inservice education for northern nurses. *The Canadian Nurse*, March, 1994. 33-36.
- Gregory, D. M. (1992). Nursing practice in native communities. In Baumgart, A.J. & Larsen, J. (Eds.). *Canadian nursing faces the future* (2<sup>nd</sup> ed.). Toronto: Mosby-Year Book, Inc.
- Groenewald, T. (2004). A phenomenological research design illustrated. *International Journal of Qualitative Methods*. 3(1). Article 4. Retrieved April 26, 2004 from [http://www.ualberta.ca/~iiqm/backissues/3\\_1/pdf/groenewald.pdf](http://www.ualberta.ca/~iiqm/backissues/3_1/pdf/groenewald.pdf)
- Guba, E.G. & Lincoln, Y.S. (1989). Fourth generation evaluation. Newbury Park: Sage Publications.
- Hills, M. (1998). Student experiences of nursing health promotion practice in hospital settings. *Nursing Inquiry*, 5. 164-173.

- Jackson, N. (1991). *Qualitative Research Methods - Why there are no recipes*.  
Class handout, p. 1-2.
- Jackson, N. (1992). *Reforming Vocational Learning? Contradictions of Competence*.  
Prepared for TAFE International Conference: What Future for Technical and  
Vocational Education and Training. Melbourne, Victoria, Australia.  
December, 1992.
- Jackson, N. (1995). *These Things Just Happen: Talk, Text, and Curriculum Reform*. In  
Campbell, M. & Manicom, A. (Eds.). *Knowledge, experience, and ruling  
relations*. Toronto: University of Toronto Press.
- Janesick, V.J. (1994). The dance of qualitative research design: metaphor,  
methodology, and meaning. In N. Denzin & Y. Lincoln (Eds). *Handbook of  
qualitative research* (pp. 209-219). Sage Publications.
- Kavanagh, K., Absalom, K., Beil, W. Jr., Schliessmann, L. (1999). Connecting and  
becoming culturally competent: a Lakota example. *Advanced Nursing  
Science*, 21(3). 9-31.
- Lawler, J. (1998). Phenomenologies as research methodologies for nursing: from  
philosophy to researching practice. *Nursing Inquiry*, 5. 104-111.
- Lincoln, Y.S., & Guba, E. (1987). But is it rigorous? Trustworthiness and  
authenticity in naturalistic evaluation. *Evaluation Studies Review Annual*, Vol.  
12 (pp. 425-436). Newbury Park: Sage Publications.
- Milligan, R.A., Gilroy, J., Katz, K.S., Rodan, M.F., & Siva Subramanian, K.N.  
(1999). Developing a shared language: Interdisciplinary communication  
among diverse health care professionals. *Holistic Nurse Practitioner*, 13(2).  
47-53.
- McCloskey, J. & Maas, M. (1998). Interdisciplinary team: The nursing perspective  
is essential. *Nursing Outlook*, 46. 157-163.
- Moccia, P. (1988). At the faultline: social activism and caring. *Nursing Outlook*  
36(1), 30-33.
- Morewood-Northrop, M. (1994). Nursing in the Northwest Territories overview.  
*The Canadian Nurse*, March, 1994. 26-31.

- N. Denzin & Y. Lincoln (Eds.), *Handbook of qualitative research* (pp.105-117). Sage Publications.
- O'Neil, J.D. (1993). Aboriginal health policy for the next century. *The path to healing: Report of the national round table on Aboriginal health and social issues*. (pp. 27-48). Ottawa: Canada Communication Group.
- Pauly, B., Schreiber, R., MacDonald, J., Davidson, H., Crickmore, J., Moss, L., Pinelli, J., Regan, S., & Hammond, C. (in press). Dancing to our own tune: Understandings of advanced nursing practice in BC. Accepted for publication, *Canadian Journal of Nursing Leadership*.
- Reverby, S. (1987). A caring dilemma: womanhood and nursing in historical perspective. *Nursing Research*, 36(1), 5-11.
- Royal Commission on Aboriginal Peoples. (1996). *Report of the royal commission on Aboriginal peoples, Volume 3, gathering strength*. Ottawa: Government of Canada, Chapter 3, pp. 107-347.
- Sadala, M.L.A. & Adorno, R.D.E C.F. (2002). Phenomenology as a method to investigate the experience lived: a perspective from Husserl and Merleau Ponty's thought. *Journal of Advanced Nursing*, 37(3). 282-293.
- Sandelowski, M. (1993). Theory unmasked: The uses and guises of theory in qualitative research. *Research in Nursing and Health*, 16(3), 213-218.
- Scott, K. A. (1993). Funding policy for Indigenous human services. *The path to healing: Report of the national round table on Aboriginal health and social issues*. (pp. 90-119). Canada Communication Group.
- Smith, D. (1987). *The everyday world as problematic: A feminist sociology*. Toronto: University of Toronto Press.
- Smith, D.E. (1975). The social construction of documentary reality. *Sociological Inquiry*, 44(4). 257-268.
- Smith, P. (1991). The nursing process: raising the profile of emotional care in nurse training. *Journal of Advanced Nursing*, 16, 74-81.

- Stapleton, S. (1998). Team building making collaborative practice work. *Journal of Nurse-Midwifery*, 43(1), 12-18.
- Sutherland, R.W. & Fulton, M. J. (1990). *Health care in Canada: A description and analysis of Canadian health services*. Ottawa: The Health Group, Chapter 3,
- Taylor, J. (1994). Non-Native Teachers Teaching in Native Communities. In M. Battiste & J. Barman (Eds.), (1994). *The circle unfolds*. (pp. 224-242). Vancouver: University of British Columbia Press.
- Thompson, N. (1995). *Theory and practice in health and social welfare*. Buckingham: Open University Press. (Chapter 1 *Theory and practice: Thinking and doing* & Chapter 2: *What is theory?*)
- van Manen, M. (1997). *Researching lived experience: human science for an action sensitive pedagogy* (2<sup>nd</sup> ed.) London: The University of Western Ontario.
- Witkin, S.L. & Gottshalk, S. (1988). Alternative criteria for theory evaluation. *Social Service Review*, June, 211-224.

## Appendix A

### Telephone Script for Recruiting Participants

## Appendix A

### Telephone Script for Recruiting Participants

Hello (Participant's name). This is Anna Beals. I am a registered nurse who has worked for several years in the Northwest Territories. I am currently doing a research project to satisfy requirements for my Master's degree in Nursing through the University of Victoria. The study explores the concept of collaboration in the practice of nurses working in northern First Nations Communities. Because I am familiar with the health centers in the Northwest Territories I have chosen to focus my research on the experiences of nurses who have worked or are currently working in the Northwest Territories. I am interested in talking to nurses who have at least 5 years of nursing experience in a northern setting. How long have you worked in the north?

[If the person says that they have less than five years experience] I'm afraid I can only include people who have at least five years of northern experience, but thank you for the opportunity to tell you about my study and I apologize for the intrusion. Have a pleasant day/evening.

[If the person has five years of experience in the north]. I'd like to tell you a bit more about my project and then invite you to participate. May I take a few minutes of your time to tell you about the study and what participation would involve?

[If the person says no] Thank you for the opportunity to tell you about my project. I apologize for the intrusion. Have a pleasant day/evening.

[If the person says yes]. As I mentioned, the purpose of my study is to explore the concept of collaboration in the practice of nurses working in Northern First Nations Communities. I am interested in knowing about how you understand and engage in collaboration in your practice. I am also interested in learning about

the supports and challenges you experience in collaborating with clients, nurses, community members, and other health and social service providers.

Your participation is entirely voluntary. If you agree, participation will involve a 60 to 90 minute interview to be done in a location of your choosing, sometime during the month of [month]. You are free to withdraw from the study at any time without consequence.

The interviews will be audio-taped and transcribed for analysis. Your anonymity will be preserved because of the transient nature of nurses in the north and because of the very large number of nurses who pass through health centers in one year (i.e.: 70) means that it is unlikely that any one nurse can be identified. You will not be asked to reveal information about particular people, rather, you will be asked only for descriptions of your experiences related to collaboration. Only the principal researcher will have access to the information obtained as it will be kept in a locked cabinet in the principal researcher's residence. If you agree to participate, I will send you a consent form containing more details about the study and the procedures for the interview. Are you willing to participate in this study?

[If person says no]. Thank you very much for the opportunity to tell you about my project. Have a pleasant day/evening.

[If the person says yes]. Thank you very much. I will be contacting you by telephone by [date] to make arrangements for the interview. Where can I reach you at that time? Also, what address should I send the consent form to?

Thank you very much. I look forward to meeting and talking to you about your experiences of collaboration in your work. In the meanwhile, if you have any questions or need to contact me at any time, please call me at [phone] or send me an email at [email address].

## Appendix B

### Participant Consent Form

## **Appendix B**

### **Participant Consent Form**

*Northern Expressions: Understanding Collaboration in Northern Canadian Nurses' Practice*

You are being invited to participate in a study entitled Northern Expressions: Understanding Collaboration in Northern Canadian Nurses' Practice that is being conducted by Anna Beals. Anna Beals is a graduate student in the department of Nursing at the University of Victoria and she has several years of nursing practice in various communities in the Northwest Territories. You may contact her if you have further questions by telephone at (780) 464-2031 or e-mail [anna\\_beals@yahoo.com](mailto:anna_beals@yahoo.com).

As a graduate student, she is required to conduct research as part of the requirements for a Master's degree in Nursing. It is being conducted under the supervision of Marjorie MacDonald, a faculty member in the School of Nursing, and you may contact her at (250) 472-4256 or e-mail [marjorie@uvic.ca](mailto:marjorie@uvic.ca).

The purpose of this research project is to explore and describe how nurses in a First Nations' community in Canada's Northwest Territories understand collaboration in their practice. The research will endeavor to bring to light the contextual influences that impact collaborative nursing practice by discovering the challenges and supports present within the nurses' practice in a northern First Nations' community.

Research of this type is important because by exploring collaboration in the practice of nurses in northern Aboriginal communities, the practical and experiential knowledge of northern nurses will help us to understand the nature of collaboration in this setting.

You are being asked to participate in this study because you are a registered nurse who is practicing or has practiced in the Northwest Territories and you have at least 5 years of nursing experience in Canada's northern territorial setting.

Your participation in this study will include an in-depth interview session that will be approximately 60 to 90 minutes in duration. Other than your work place, interviews will be held in a setting that is mutually agreed upon by you and the principal researcher. With your approval, the interview will be audio-taped and then transcribed. The interview will focus on your understanding of collaboration, how you use collaboration in your nursing practice, and the challenges and supports for collaboration that you have experienced.

It is anticipated that the 60 to 90 minute interview will be the only inconvenience for you as a participant in this study. The interviews are not intended to cause any distress to you. However, because you will be discussing personal work experience there may be some chance that emotional anxiety may arise related to distressing work situations. You may interrupt or terminate the process at any time should you experience any distress. To prevent or to deal with this the principal researcher will have resource information available for the participants should they request or require support (i.e., contact number and resource material for the Employee Assistant Program of the Government of the Northwest Territories, counseling resources).

The potential benefits of your participation in this research include an increased awareness of collaboration in your practice and enhancement of your knowledge base. As well, you will be contributing your practical and experiential knowledge about collaboration with clients and colleagues in nursing practice. This will enhance the understanding of the nature of collaboration in northern nursing practice and may contribute to the refinement and revision of the Canadian Nurses Association Framework on Advanced Nursing Practice.

Your participation in this research is completely voluntary. You should not take part in the research if you are reluctant to participate but feel obligated because of your relationship to the principal investigator. If you do decide to participate, you may choose not to answer any given question and may withdraw at any time without any consequences or any explanation. If you do withdraw from the study, any information regarding the research that is provided by you to the principal researcher up to the point of withdrawal will not be used in the analysis without your permission. If you do not provide permission for use of the information then it will be destroyed.

To protect your anonymity your name will not appear on the interview audiotapes, in the audiotape transcriptions, or in any other research related documentation. All other identifying information (i.e., dates, specific time frames, places) will be removed from the transcribed data. A transcript of your interview will be available upon your request. In reporting the data, only quotes or examples not containing identifying information will be used.

Your confidentiality and the confidentiality of the data you provide will be protected by ensuring that only the principal researcher has access to the data. It will be kept in a locked filing cabinet in the researcher's home. You will not be asked to reveal information about particular people; rather, you will be asked only for work descriptions. The data will only be used for the purposes of this research project. Audio taped interviews will be erased and the paper transcripts will be shredded once the research project is completed and degree requirements have been met.

It is anticipated that the results of this study will be presented in a written thesis and oral presentation that are required by the University of Victoria to complete my degree program requirements. A written summary of the results will be provided to you on completion of the study, and a copy of the completed thesis will be made available upon your request. It is also possible that the results of the research project may be presented at a nursing conference or written up as an article for publication. In reporting the data, no quotes or examples will be used that contain information that could be used to identify you.

In addition to being able to contact the researcher and her supervisor at the above phone numbers, you may verify the ethical approval of this study, or raise any concerns you might have, by contacting Dr. Howard Brunt, the Associate Vice-President, Research at the University of Victoria (250-472-4632).

Your signature below indicates that you understand the above conditions of participation in this study and that you have had the opportunity to have your questions answered by the researchers.

---

Name of Participant	Signature	Date
---------------------	-----------	------

A copy of this consent will be left with you, and a copy will be taken by the researcher.

## Appendix C

### Sample Interview Questions

## Appendix C

### Sample Interview Questions

1. Please tell me about your educational and northern nursing experience background.
2. What does collaboration mean to you in your northern nursing practice? How would you describe collaboration in your practice?
3. What kinds of challenges have you experienced as you establish a collaborative way of practice and how did those challenges impact your practice?
4. What are some ways that you find support for collaborative practice?
5. What aspect of your work do you find most challenging in establishing an effective way of collaborating with clients? nursing colleagues? other health care practitioners?
6. How does communication play a role in collaboration? Possible probes – language? Translation?
7. How do you bring your understanding of other disciplines into establishing a collaborative way of practice?
8. How do you think conflict would affect collaboration? Can you describe a conflict situation you have been in, how you managed it, and how it affected the process of collaboration?
9. In what way does collaboration contribute to your nursing practice?
10. What effect does collaborative nursing practice have on the provision of health care in the north?
11. Who are the primary people you collaborate with in your practice? Can you describe an incident involving collaboration with each of these?
12. As a nurse working in a northern setting, what knowledge base do you need to collaborate effectively?

Appendix D  
Ethics Approval



University  
of Victoria

**Human Research Ethics Committee**  
Office of the Vice-President, Research  
University of Victoria  
Room 425 Business and Economics Building  
Tel (250) 472-4545 Fax (250) 721-8960  
Email ovprhe@uvic.ca Web www.research.uvic.ca

## Human Research Ethics Committee Certificate of Approval

<u>Principal Investigator</u> Anna Beals Graduate Student <u>Co-Investigator(s):</u>	<u>Department/School</u> NURS	<u>Supervisor</u> Dr. Marjorie MacDonald	
<u>Project Title:</u> Northern Expressions: Understanding Collaboration in Northern Canadian Nurses' Practice			
<u>Protocol No.</u> 349-02	<u>Approval Date</u> 10-Oct-02	<u>Start Date</u> 10-Oct-02	<u>End Date</u> 09-Oct-03

### Certification

This certifies that the UVic Human Research Ethics Committee has examined this research protocol and concludes that, in all respects, the proposed research meets appropriate standards of ethics as outlined by the University of Victoria Research Regulations Involving Human Subjects.

This Certificate of Approval is valid for the above term provided there is no change in the procedures. Extensions or minor amendments may be granted upon receipt of "Request for Continuing Review or Amendment of an Approved Project" form.

349-02 Beals, Anna