Nurses and Human Resources In Indian Communities: Nurse Perceptions Of Factors Affecting Collaboration With Elders And Contact With Traditional Healers On Indian Reserves And In Health Centres In Manitoba

by

David Michael Gregory

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NURSES AND HUMAN RESOURCES IN INDIAN COMMUNITIES: NURSE PERCEPTIONS OF FACTORS AFFECTING COLLABORATION WITH ELDERS AND CONTACT WITH TRADITIONAL HEALERS ON INDIAN RESERVES AND IN HEALTH CENTRES IN MANITOBA

BY

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A thesis submitted to the Faculty of Graduate Studies of the University of Manitoba in partial fulfillment of the requirements of the degree of

MASTER OF NURSING

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ABSTRACT

Previous nursing research has not examined the extent of collaboration between nurses and Indian Elders, and contact with traditional healers in Manitoba. An exploratory-descriptive two phase research design was implemented to identify factors affecting collaborative efforts between nursing staff and Indian Elders, and to explore nurse-healer interaction. Phase I consisted of semi-structured, face to face interviews with field nurses (N=10) and Elders (N=13) on three Indian reserves in northern Manitoba. Phase II consisted of a close-ended, structured, census survey mail questionnaire administered to nurses (N=64) working autonomously with Indian clients. Findings based on Phase I interviews and an 81.2% return rate of Phase II questionnaires indicated that nurses who were appreciative of the traditional health care system were collaborating with Elders and healers on reserves and health centres in Manitoba. The need for ongoing and indepth communication between nurses and Elders/healers was established. A more detailed cultural orientation was indicated as needed by the majority of nurses. Factors influencing the collaborative process were identified as: past transcultural experiences, knowledge of who/what Elders are, influence of the nurse's own culture and the attitude of the Elders and community towards the nurse. Client conditions identified as appropriate for Elder referral included: lack of self worth, family discipline problems, social interaction problems, child neglect, and parent-child conflict.

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To the memory of my mother

To my father who has always offered me love
and endless support in all that I do

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Chapter I

STATEMENT OF THE PROBLEM

A cultural and linguistic revival is taking place on Indian reserves in Canada (Adams, 1984). One area of Indian cultural renaissance is health care, specifically the utilization of traditional practices (Government of Canada, 1983). In areas where traditional Indian health practices have been attenuated, attempts are being made to restore traditional ways. For example, in the Kenora region of northwestern Ontario, traditional healing practices were not formally available and the local Indian people identified a need for these services. Medicine men were brought to this area in order to resurrect traditional practices and provide ongoing educational assistance (University of Manitoba Medical Journal, 1982). This resurgeance and revitalization of traditional Indian health care practices presents the nursing profession (and other health care professionals) with a significant challenge in providing quality client-centred health care.

Holistic nursing care incorporates and supports the client's cultural beliefs and values. Transcultural nursing, a subfield of the profession, espouses the provision of culture-specific nursing care. Leininger, who

was instrumental in the development of this subfield, has defined transcultural nursing as "a formal area of study and practice focused on a comparative analysis of different cultures and subcultures...with respect to cultural care, health and illness beliefs, values and practices" (1978, p. 8). Leininger acknowledged the challenge to help nurses, physicians and other professional personnel to realize that clients possess their own healing and care modes, which may be as effective as some current professional or scientific acts. She also predicted that "demands for cultural rights in health services will increase markedly in the future, and will place greater demand on nurses and physicians to go beyond mind/body treatment" (Leininger, 1984, p. 73).

This prediction has been recently actualized in Manitoba. The northern Manitoban Chiefs have requested that traditional Indian medicine be included in the Health and Welfare Canada services offered on their reserves. A resolution passed by the Chiefs and representatives of 25 bands of the Manitoba Keewatinowi Okimakanak Incorporated (MKO) stated that since "the department's [Medical Services] normal services do not cure all the ills of the Indian people, traditional medicines should be made available" ("Traditional Medicine", 1984).

Thus, nurses who are providing primary health care to Indian clients in Manitoba (Spencer, 1984) and elsewhere in Canada, need to be aware of and understand traditional

Indian beliefs and practices if a holistic nursing approach is to be sustained. This knowledge would enable nurses to work effectively with Indian clients and offer services which may be lacking or ineffective in the dominant health care system. As primary health workers, nurses provide comprehensive care and assist individuals and families to make appropriate use of the services of physicians and other professionals (Henderson, 1983). It is within this role that nurses possess the opportunity to acknowledge traditional healing systems.

Health care providers within the Indian health system range from the Elders to socially sanctioned healers. Scant research has been conducted in this area and a paucity of information exists regarding traditional Indian healing practices on reserves and health centres in Manitoba. No current abstracts examining the extent of contact and interaction between nurses and traditional healers were identified in the literature review. Key Indian informants were contacted and the investigator was advised that ethnomedicinal practices are being carried out to varying degrees on reserves and health centres within the province.

The health care profession has traditionally maintained a suspicious and often skeptical stance regarding indigenous healers and their health care systems. Recent literature indicated a profound but cautious change in attitude. Given the minimal documentation of traditional Indian health care

practices within the province of Manitoba, and the hesitancy on the part of the Federal Government to actively promote and enhance collaborative/interactive relationships between health care workers and traditional healers, this study focused on factors affecting collaborative efforts (actual and potential) between nursing staff and Indian Elders. The utilization of Elders as health resource persons was explored, as well as the extent of contact between nurses and traditional healers. It should be noted that many Indian Elders are also traditional healers, thereby limiting attempts to formally dichotomize subject groups as strictly Elders or traditional healers.

A booklet produced by Health and Welfare Canada (Medical Services Branch, Pacific Region) entitled, The Teaching of the Elders, (1982), offered insight into the social and cultural importance of Indian Elders. As noted in the booklet's introduction, Elders "are the teachers of our [Indian] culture" (p.1). The booklet demonstrated that Elders were a legitimate source of knowledge and cultural information. Couture (1979) stated that "Elders are superb embodiments of highly developed human potential", and praised their qualities; "intuition, intellect, memory, imagination...their profound and refined moral sense...a high level of spiritual/psychic attainment..." (p. 7). This author urged that Elders be given careful attention and possible emulation. It is the Elders' self-actualization

that offers potential for native health programs and for the full range of native educational development (Couture, 1979).

The employment of an Elder in a native alcohol treatment centre (Poundmaker's Lodge in Edmonton) was noted by Grescoe (1977). The Elder was described as "wise in Indian culture" and "conduct[s] traditional pipe ceremonies and advise[s] troubled youngsters" (p. 121). The counselling role of Elders has also been documented and advocated by Rodgers:

> elders are important people...suffice to say that some native traditional leaders and elders have an excellent grasp of psycho-social dynamics and are respected as counsellors in the communities, even by the "modern generation" to some extent (Rodgers, No date, p. 10).

The Shamattawa Indian Band in northern Manitoba, which has experienced severe solvent abuse (sniffing) has, as part of their community development, engaged Elders in the treatment of their young people (Menary, 1979). Although limited, the literature identified Elders as a valuable resource in terms of counselling and guidance, preservation of culture, and the survival of Indian People.

The term Elder does not automatically ascribe advanced age status to the identified individual. One "becomes" an Elder through actions/advice which demonstrate wisdom and good judgment sense. Elders assist the Indian People in survival and actively contribute to the community in some capacity. It would appear that the majority of Elders are

senior citizens though, and this has significant ramifications for nursing personnel.

Most of the social science research conducted on non-Indian elderly persons focuses on this group as passive beneficiaries who act as a drain on the energy and resources of those closest to them (Stueve, 1983). In an elegant investigation, Stueve examined the role of the elderly as active members in informal and formal social networks. She concluded that "many elderly still have much to offer age peers and other generations in their role as family members, friends, neighbors, natural helpers, and volunteers" (p. 83). This fresh perspective on the elderly is difficult to formulate since "...characterization of the elderly as active network contributors and community participants is out of step with many of our cultural images and beliefs about old age" (Stueve, 1983, p.60).

Northern nurses therefore face several challenges in the collaborative process with Elders as health resource personnel. First, they may have to overcome stereotypes of the aged; and second, they are treating clients who in certain instances may benefit from counselling sessions with individuals who are members of the non-formal health care system. This second challenge is based on the premise that the client will be receptive to counselling provided by the Elder(s), and the practitioner's recognition and appreciation for the alternate health care system.

Recognition and appreciation of the alternate health care system is also fundamental in determining the intensity of interactions between nurses and traditional healers.

It is not suggested that all Indian people would be comfortable with counselling sessions provided by the Elders. Nurses would have to be sensitive to clients and assess whether a referral to an Indian Elder would be an acceptable practice. As well, not all Elders may be comfortable in counselling community members and nurses would have to establish which Elders are supportive of a client counselling role.

The questions which guided this research were:

1. What factors are perceived by nursing personnel as affecting collaboration (actual or potential) with Indian Elders in terms of counselling clients?
2. What is the extent of knowledge nurses possess regarding the role of Elders in community health?
3. Are nurses currently involved in the referral of Indian clients to Elders?
4. Have the referrals to Elders been successful in terms of client functioning?
5. To what extent and how are Indian communities sharing knowledge of traditional healers and Elders with their nurses?

6. What is the extent of contact between nurses and traditional healers?
7. What are the existing client referral patterns to traditional healers?

Nurses working as primary health care workers could contribute significantly towards quality of care by referring clients to traditional healers or Elders when warranted. This practice would enhance the holistic approach which the nursing profession advocates and would assist Indian clients in preserving and developing their own health values. This study was directed towards gaining knowledge regarding transcultural nursing practices on Indian reserves and health centres in Manitoba. Specifically, factors influencing the collaborative efforts between nurses and Elders in terms of client counselling were examined. As well, the extent of nurse-traditional healer contact was explored. Traditional Indian medical practices were not explored, nor actively sought from research subjects.

Chapter II

CONCEPTUAL FRAMEWORK

Three theoretical perspectives were integrated to form the conceptual framework for this research. These included:

1. Adaptation In Cultural Evolution (Alland, 1970);
2. The Sociology of Perception (Douglas, 1982);
3. Interaction Goals As Bases Of Inference In Interpersonal Perception (Jones, E., and Thibaut, J., (1958).

Alland (1970) developed a system's perspective of cultural development while at the same time embracing concepts of biological evolution. Cultural development or evolution has been identified as an opportunistic process and is capable of rapid change in both quality and direction. It involves the development of stable systems which are maintained through negative feedback. Negative feedback has been identified as one of the major forces in the cultural evolutionary process. Stability in systems reflects the conservative force of adaptation in which systems maintain themselves through time. Alland's concepts were applied with regards to the relationship between the traditional Indian health care system and the dominant Western health care system.

The dominant western health system aided by environmental (smallpox, tuberculosis, etc.), political (establishment of the reserve system, B.N.A. Act, etc.), and religious events (conversion of the Indian tribes to Christianity), served to abate and erode the existing traditional healing systems over time (Cardenas & Lucarz, 1985). Alland posited that "populations carrying more efficient systems replace or absorb populations carrying less efficient systems if such groups are competing for the same environment" (1970, p. 180). As O'Neil (1981) noted with the Inuit, cosmopolitan medicine demonstrated an ability to reduce morbidity and mortality significantly and because of this, the Inuit accepted its benefits. This observation can be logically applied to the Indian people as well. The traditional healers could not compete with the powerful and apparently effective western health care system. As a result of this occurance, a massive wave of diffusion was initiated, with the major "flow" originating from the western health system and severely diluting the traditional healing system.

At present, the Indian people are experiencing a cultural renaissance. It is within this growth process that Indian people are voicing their concerns regarding the western health system. They are claiming this system is not adequate in coping effectively with many of the ills of their (Indian) society. Jilek (1982) identified that it is not due to the lack of modern treatment services that a

revival of indigenous healing ceremonials has occurred. "It has to do with a lack of culture-congenial and holistic approaches in modern medicine" (p. 161). In general terms, the dominant health care system is currently being perceived as a less effective system. Health statistics available from Indian Affairs and Northern Development (1980) in Indian Conditions: A Survey, document the foundations for these perceptions.

According to Sahlins and Service (1960), "[a] cultural system which more effectively exploits the energy resources of a given environment will tend to spread in that environment at the expense of less effective systems" (p. 75). Thus, it is proposed that a second major wave of diffusion is taking place, a century or more following initial cultural diffusion. This "wave", with its emphasis on traditional Indian values, can be viewed as an attempt to ensure Indian survival. Currently, the "flow" is originating at the grass roots level and is pervading the dominant health care system: Medical Services.

The Indian people, as recipients and consumers of health care have identified a deficit in the existing health care system. Due to a vast array of complex factors (economic, political, ecological, social and cultural), the Indian people find themselves in a state of disequilibrium. This state of disequilibrium is requiring additional energy costs in terms of system functioning and as a result, Indian

people are now requesting options in conjunction with the western health system in order to compensate for some of these costs. Traditional medicine is being created anew in order to cope with the problems and stresses that plague Canada's indigenous people. The traditional medicine that is resurfacing however, has undergone evolutionary changes and development and is not simply a direct copy or duplication from earlier times. Recent interests in traditional Indian culture and healing are being invested in order to maximize survival and minimize destructive forces. Elders are being approached by an increasing flow of Natives seeking advice and counsel, healing and inspiration, interpretation of the past and present which are the prerequisites for future survival (Couture, 1979).

It is naive and unrealistic to propose that a complete replacement of the existing health system by a traditional healing system would take place. A blending or melding of the two systems is more likely to transpire. This scenario was acknowledged by the Department of National Health and Welfare which stated that:

> a combination of traditional practices and western medicine could be a powerful force for healing particularly those illnesses caused by the intolerable social environment in many Indian communities as evidenced by high rates of violence...It could also be a positive step in the enhancement of Indian culture and traditions and in the re-awakening of pride in Indian achievement (Canada, 1980, p. 72).

Alland suggested that cultures undergo evolutionary changes as a result of system interface. In other words, cultural evolution transpires as a result of various system interactions. Suffice to note that this process is indeed complex and a detailed examination is beyond the scope of this thesis. Four key systems involved in the nurse-client referral process to Elders have been identified. They included:

1. the nursing profession
2. Indian communities
3. the dominant health care system (Medical Services)
4. the indigenous health system (traditional healers and Elders)

The goal of transcultural nursing interventions is to assist clients in attaining health equilibrium based on the provision of culturally oriented nursing care. The practice of transcultural nursing with respect to Indian clients is accomplished through an intimate understanding of the identified key systems. That is, a working knowledge of the structure, function and relationships of the key systems is essential in the delivery of transcultural nursing care. Scrutiny of this system interface provided the opportunity to integrate the various theoretical perspectives (Alland, Douglas, Jones and Thibaut) in order to examine nurses' perceptions of factors influencing collaboration with Indian Elders.

Douglas (1982), in The Sociology Of Perception suggested that anything which is perceived must pass through perceptual controls. Data is admitted; some may or may not be rejected; and some is supplemented to make the event cognizable. The process is largely cultural. Cultural input therefore, plays a major role in the perception process, and consequently a nurse's cultural orientation will shape perceptions of factors which influence his/her decision making. Douglas attempted to systematize cultural constraints. She developed a two dimensional group-grid model which reduces social variation to only a few grand types. The author stated that there are two dimensions of control over the individual:

1. group commitment: strength of allegiance to a group (For example, a learned profession) and,
2. every remaining form of regulation. This is the grid component. (For example, laws, policies etc.)

Combined, four extreme visions of social life are produced.

HIGH GRID Atomized Subordination (B)	Ascribed Hierarchy (C)
(A) Individualism LOW GRID LOW GROUP	(D) Factionalism HIGH GROUP

Thus, there are four possible social environments in which an individual may be found.

1. (A) Low grid/low group: Allows options for negotiating contracts or choosing allies and in consequence, it also allows for individual mobility up and down whatever the current scale of prestige and influence. (Individualism)
2. (B) High grid/low group: Ascribes closely the way an individual may behave. They do as they are told without the protection and privileges of group memberships. (Atomized subordination)

3. (C) High grid/high group: Environment of large institutions where loyalty is rewarded and hierarchy is respected. An individual knows his/her place in a world that is securely bounded and stratified. (Ascribed Hierarchy)
4. (D) Low grid/high group: Defined by a form of society in which only the external group boundary is clear. (Factionalism)

The ascribed hierarchy cell (C) is of particular interest. Medical Services nurses function within a bureaucratic institution where loyalty is rewarded and hierarchy is respected. In terms of Douglas' framework, this group possesses a mutual commitment and is highly regulated. Thus, the characteristics of the individuals identified in the ascribed hierarchy cell appear to be appropriate and relevant to the providers of Indian health care (nurses).

Jones and Thibaut (1958) proposed that an individual interacts with three kinds of goals:

1. Facilitation of personal goals: Promotes the arousal of value-maintenance.
2. Deterministic analysis of personality: Social, physical and biological determinants cause an individual to behave as he now does. (Causal-genetic set)

3. Application of social sanctions: Generalized norms which the individual considers to be applicable to the present behaviour setting. (Situation-matching set)

The similarities between Douglas (1982) and Jones and Thibaut (1958) become apparent. Analyzing the system interface which was developed based on Alland's (1970) concepts, and applying the theoretical thrusts behind Douglas, Jones and Thibaut, the identification of possible factors influencing the perceptions of nursing staff was facilitated. The theoretical similarities were identified as follows:

1. influence of culture
2. influence of personality
3. professional and personal gratification
4. maximizing beneficent social response
5. generalized (personal, social, environmental) norms/rules
6. professional and personal goal attainment

Based on the input from Douglas, Jones/Thibaut and Alland, two factor clusters which may influence perception were developed. They included: external and internal factor groups. Environmental factors were considered as a sub-group of the external factors. These groups incorporate the identified factors and may influence the perception of nursing personnel in terms of Elder collaboration.

2.1 EXTERNAL FACTORS

External factors are those which come to bear upon the nursing professional. Nurses occupy a niche within the Medical Services hierarchy and according to Douglas, are a high grid/high group social typology. It is postulated that nurses in this social group would tend to respect authority and therefore, perception of institutional policies regarding utilization of alternative healing systems (in this instance, Elders for counselling purposes or traditional healers for client treatment) may have a significant impact on decision-making. It is acknowledged that other social typologies may exist within the Medical Services milieu. For example, individualism may occur inspite of the fact that the majority of nurses would have to display attributes conducive to survival within the institutional organization.

Formal and informal input from Zone Nursing Officers may affect perceptions. Allegiance to the group (ie. what other nurses think of transcultural nursing practices, particularly the Nurse-In-Charge) may also affect nursing personnel perceptions. This last external factor directly embraces Jones and Thibaut's concept of application of social sanctions, in terms of peer group support.

2.1.1 Community/Social Factors

Community/social factors are presented as a subsystem of the external factor group. The distinguishing feature of these factors is related to the effects on the process of Elder collaboration, rather than on the concept of perception itself. For example, the degree to which Elders are respected and valued within a particular Indian community may not influence the nurse's perception or concepts regarding Elder collaboration, but may have substantial implications in terms of process implementation. Another example includes the identification of Elders. Identification of Elders may not affect perception of Elder collaboration per se, but it may have significant consequences in the initiation of the referral process.

Some factors involve participation and involvement on the part of the nursing professional. For example, the trust that exists between the nurse and the community/Elders may affect the client referral process to Elders. A trust is formed based on the quality of the relationship between health care provider and the community. (The length of time a nurse is in a community may affect this factor.) The level of trust established may not greatly affect the nurse's perceptions of Elder collaboration but may influence the willingness of Elder participation.

2.2 INTERNAL FACTORS

These factors are related to the influence of culture, personality, personal gratification and goal attainment on the part of the nursing professional. The deterministic analysis of personality comes into play, whereby the nurse's socialization is offered as a factor in collaborative work with Elders. As well, exposure to transcultural nursing concepts and the identification of the role and function of Elders/traditional healers are factors which may influence the decision-making process.

2.3 SUMMARY

The research process attempted to identify perceived factors which influenced nurses' decision making processes regarding Elder collaboration. The factors discussed here are not exhaustive in number and scope but are provided as examples to demonstrate the concepts identified by the integration of the various theoretical perspectives.

Nurses, as primary health care workers, occupy a niche in the system interface setting and as such can impede or enhance recent Indian cultural developments through manipulation of institutional power. The conceptual framework has identified two factor clusters and the aim of the research proposal was to identify and substantiate which factors were perceived by nurses as instrumental in enhancing or detracting from Elder collaboration.

Chapter III

REVIEW OF THE LITERATURE

3.1 INTRODUCTION

An examination and analysis of the various disciplines and individuals interacting at the system interface position identified in the conceptual framework will be presented.

3.2 THE HEALTH CARE SYSTEM: MEDICAL SERVICES ORGANIZATION

The primary goal of the Federal Indian Health Policy announced in 1979 was to increase the level of health in Indian communities. This commitment is being actualized on Indian reserves and in remote northern areas through a variety of mechanisms including active Indian consultation, joint planning processes, client defined programs, affirmative action plans, and by the maintenance of nursing stations and regional hospitals run by the Medical Services Branch (MSB) of the Department of Health and Welfare Canada (Department of National Health and Welfare, 1981, p. 13).

MSB possesses a comprehensive organizational structure with a central headquarters in Ottawa. For the purposes of administration, Canada is divided into regions and each region is subdivided into zones. Manitoba Region is divided

into two zones: the North Zone Office is in Thompson; the South Zone Office is located in Winnipeg and the regional headquarters for both zones is also located in Winnipeg. The zones are the operational level; that is, they deal directly with the Indian people. The Zone Office also provides a major resource service to the staff of the field units.

The backbone of the health delivery system is the nursing and community health representive (CHR) staff. Nursing station staff provide a primary level of health care. Although the stations are designed for out-patient care, beds are available for medical emergencies awaiting evacuation, or such conditions as spontaneous uncomplicated childbirth. Physicians, physician-specialists and dentists among others, provide services to the various Indian communities on a regular basis. They also conduct in-service sessions for the nursing and support staff.

As part of the cultural orientation provided by MSB, nurses are presented with information related to traditional health care approaches. Nursing staff are informed "that a number of traditional native practices are equal to or, given the isolated environment of some communities, even superior to those of modern medicine" (MSB, 1984, p. 10). MSB also advocates that health care workers who display a respectful interest in Indian medicine are more likely to gain the confidence of their clients. One of the weaknesses

of modern medicine is noted: "modern medicine ignores the need for necessary social support" (p. 11).

In a speech presented at a symposium on local Indian health control, the Regional Nursing Officer for Manitoba Region (Medical Services Branch) acknowledged the presence and influence of traditional healers on reserves:

> Most of the people that come to you [nurses] have been to someone else before you and that is usually the local medicine-man and that is quite all right. We accept that quite well, and I want you to understand that this is a fact of life... (Dozois, 1977)

Indian people who request the services of a medicine man/woman are assisted by Medical Services. Transportation costs incurred with travel to another reserve have been subsidized by the Zone Office. Manitoba region of MSB has provided transportation funding for those clients who wish to obtain treatment from a medicine man/woman if unavailable in their own communities. Medical Services does not financially compensate the healers for their services as the payment of money for the services of a healer is considered inappropriate and possibly contributing to the undermining of traditional medicine (Jackson, 1980).

National Health and Welfare officials submitted their views regarding traditional medicine in the Indian Self Government Report, (Government of Canada, 1983).

> We have come to appreciate very much the relevance and the utility of traditional approaches, particularly to mental health problems-approaches

> which address the suicide rate, approaches which address addiction problems...the application of traditional medicine and native culture perhaps can be more successful than anything we could offer in terms of contemporary psychiatric approaches to those kind of problems. (p. 34)

In 1979, MSB suggested that practitioners of traditional Indian medicine should participate in health services. It was suggested at the time, that the paucity of programs which utilized Indian healers was due to the ignorance of traditional Indian religion and culture on the part of non-Indian health care givers. An approach of acceptance towards Indian medicine was advocated.

> In the areas of the country where traditional Indian medicine is still important, we should encourage a closer working relationship between traditional healers and physicians, perhaps through a program designed by an anthropologist or other individual knowledgeable about both western and traditional medicines. (Canada, 1980, p. 72)

The Department of National Health and Welfare also acknowledged the provision of <u>counselling</u> and spiritual guidance by Indian healers [Elders].

The literature supported a significant improvement in the quality, continuity and availability of acute care medicine provided by Medical Services, but long-term improvement in the health status of the communities is seriously limited by the use of an urban medical model in remote facilities and the involvement of outside agencies in health service delivery (Morison, 1974). Several authors also documented the need for change in the organization of care and a more

substantial cultural orientation for health care personnel (Morison, 1974; O'Neil, 1981; Stymeist, 1972). It would appear the Department of National Health and Welfare supports the utilization of traditional healers where appropriate. This support however, seems limited more to ideological rhetoric rather than the actualization of this philosophy in terms of daily field-unit activities.

The northern Manitoban Chiefs have requested that traditional medicine be included in the Health and Welfare Canada services offered on their reserves (Traditional Medicine, 1984). The Indian people are not satisfied with the current health care services and are requesting recognition of their own health care system. Health and Welfare Canada has been advocating a closer working relationship between traditional healers and health care workers since 1980 and yet, no formal collaborative or integrative health programs between Medical Services personnel and Indian healers were identified.

3.3 INTERNATIONAL AND CROSS CULTURAL HEALTH CARE

The World Health Organization-UNICEF declarations on primary health care, at Alma-ata, USSR, in 1978 offered direction vis-a-vis utilization of local human resources in communities. Among the ten declarations related to primary health care, number VII has implications for MSB. Primary health care:

> relies at local and referral levels, on health workers, including physicians, nurses, midwives, auxiliaries and community workers as applicable, as well as traditional practitioners as needed, suitably trained socially and technically to work as a health team and to respond to the expresssed health needs of the community. (Government of Canada, 1980, Appendix 3)

Although Canada is a signatory to the Declaration, MSB acknowledged that it too often continues to operate health programs for Canada's Indian people that are frequently paternalistic, overly bureaucratic and tend to isolate health from the social, economic and spiritual aspects of life (Canada, 1980). Skeet (1981) reinforced the WHO policy on traditional medical practices. She advocated that member states of the WHO identify good practices in traditional medicine and integrate traditional healers into each country's health care system. Although supportive of the WHO policy, the identification of good practices becomes problematic. It is suggested that traditional healers may be resistant in exposing their works for evaluation and scrutiny.

At the national level, the Government of Canada's Indian Health Policy advances "community development, both socio-economic development and cultural and spiritual development" (Government of Canada, 1980, Appendix 2). This position, as articulated by the Federal Government acts as input towards the health care system, and as a branch of the federal government, Medical Services must deal with this national

input. That is, MSB possesses the responsibility to actualize the commitments made by the Federal Government within the international political setting. These commitments appear limited to the confines of international agreements, rather than implementation on a national or regional basis. Maintaining a positive standing within the international political arena would appear to take priority over enhancing the health care system for Canada's Indian people.

3.4 PHYSICIANS AND ALLIED HEALTH PROFESSIONALS

The majority of the current medical literature presented by physicians and allied health professionals supported the utilization of traditional healers, especially in the area of counselling and psychotherapy. Beliefs that the medicine man's usefulness had expired (Fiddes, 1965) were in the minority. Medical opinion has been building up in favor of employing the medicine man institution and folk healers for the purposes of modern psychiatric care (Jilek, 1971; Ostendorf & Hammerschlag, 1977; Todd, 1975).

Elling (1981) has indicated two distinct views regarding traditional medicine. There are serious grounds for doubting the efficacy of much traditional medical practices and yet there are many proven examples of efficacious specific medicines and treatments. According to Kleinman and Sung (1979) indigenous healers (in Taiwan) are often

viewed by western physicians as dangerous because they cannot define a disease in scientific terms and often fail to treat it, which could have potentially disastrous effects for patients. Although certain isolated deleterious traditional practices were identified, the positive aspects of traditional medical systems were praised by the majority of the physicians.

Lessons for modern healers based on the actions and philosophies of traditional healers have been offered by Martin (1981). This physician identified the task of the healer as helping the patient mobilize psychological and spiritual, as well as bodily resources. Martin suggested that posttraditional healers should account for "physician philosophy, patient faith, healing ceremony, patient illness beliefs and family participation" (Martin, 1981, p. 143). It is suggested that certain Elders/traditional healers would be more than capable of accomplishing these tasks. Traditional healers address these areas and Martin forwarded that posttraditional healers should examine their own healing practices in relation to these variables as well.

The costs of modern health care are rising very rapidly and serious challenges have arisen to its iatrogenicity and overall effectiveness (Illich, 1975). This situation may encourage governments to identify more inexpensive but effective methods of providing adequate health care. In relation to Indian clients, Elders/traditional healers may

play a key role in keeping the health care costs to a minimum as well as providing effective health care. This perspective was supported by Mardiros (1986) who suggested that "with health care costs rising, alternatives that rely on self-help and preventive health care must be sought. Traditional medicine is one such alternative" (p. 15).

According to Rodgers (1979) "various native healers either in this city (Winnipeg) or in rural areas of the prairies have been utilized in the collaborative manner with varying degrees of success" (p. 11). In Manitoba, there appears to be a number of levels of healing or curing persons in the Indian communities. Rodgers has identified the following types of healers:

1. Medicine Man: Traditional spiritual leader. Possesses a knowledge of folk medicine and its application. He is the guardian and purveyor of his people's customs. Therapeutic system involves shrewd analysis, medicines, direct advice, family counselling and community support.
2. Medicine Men/Women: Not spiritual leaders but are respected Elders of the community. Skilled herbalists.
3. Elders: Primary therapists in the psychiatric sense and in the psychosomatic illness sense. They are the chosen Elders. (p. 12-14)

Rodgers advocated that health-care providers work with these identified individuals in a spirit of true mutual collaboration. Clients with emotional problems of everyday living would probably receive reliable and adequate care from the spiritual leaders. "In the more serious depressions and psychotic disorders, a collaboration between modern medicine and the native man's view in dealing with the spiritual aspects and the community aspects would seem to be ideal" (Rodgers, 1979, p. 16). This suggested collaborative effort was also offered at the WHO-UNICEF International Conference on Primary Health Care in Alma-Ata. One of the recommendations at this conference identified that traditional practitioners can become important allies in improving the health of the community (WHO-UNICEF, 1978, in Slikkerveer, 1983). Ragan (1980) also noted the social acceptability of the traditional healer. Healers provide care based on an existing social, cultural and religious background as well as on the knowledge, attitudes and beliefs that are prevalent in the community with regards to physical, mental and social well-being. The traditional healer is accessible in that the client does not have to overcome cultural barriers.

Traditional healing appears effective in conditions in which psychoneurotic and psychophysiologic mechanisms are prominent (Jilek & Jilek-Aall, 1972). In these authors' experience, such Indian cases have benefited more from

indigenous therapeutic procedures than from medical attention. The authors found that a cooperative relationship with Indian therapists detached the psychiatrist from the Indian-White conflict, reduced the cultural barrier between the psychiatrist and clients, and made individual psychotherapy more effective. Employment of Indian medicine in the treatment of psychoneurotic and psychosomatic illness has also been noted by Orchard (1974).

Jilek and Todd (1974) found a remarkable improvement in the mental health of Salish Indians who were initiated into the Native Winter Spirit Dancing Society. The rituals seemed to help those individuals with behavioural problems often associated with alcohol abuse, and those with depression and other symptoms. Jilek (1982) posited that the "Indian alcohol problem" may be taken as an epidimiologic indicator of the prevalence of anomic depression in the native population of North America. He noted that orthodox Western medical and psychiatric treatment attempts have been rather ineffective, and are limited to palliative crisis intervention. Jilek's work amongst Canada's Salish Indians identifies spirit ceremonials as providing most of the active participants with sobriety and a reduction of alcohol abuse. This phenomenon has occurred to such an extent that Jilek suggested the ceremonials "should be ranked with the major therapies of alcoholism" (p. 99). This finding applies to

those Indians who are familiar with and have faith in spirit dancing.

Thus, the importance of traditional healers is supported and advocated, particularly from a mental health perspective. The field of mental health would appear to be an acceptable area where the use of indigenous healers and Elders can be effectively embraced. According to Miller (1982), "in all of the literature (social work, medical, nursing, psychology) concerned with transcultural service delivery, there is agreement that mental health professionals do not currently have adequate knowledge for consistently sensitive and effective transcultural interactions with clients" (p. 176).

Several physicians have documented that governmental policies reinforce the trend of keeping indigenous medicine essentially marginalized (Jeffery, 1982; Newmann & Lauro, 1982; Pillsbury, 1982) while at the same time acknowledging the respect for indigenous systems through international developmental agencies such as the World Health Organization and UNICEF. "Although the benefits of incorporating traditional healers has been established it appears that little progress has been made in actually utilizing indigenous health practitioners, especially healers in national systems" (Pillsbury, 1982, p. 1827). It is suggested the Federal Government has acknowledged respect for indigenous healing systems at the international level,

while simultaneously maintaining the marginality of Indian healers at the national and regional levels.

A native healer program has been recently established in Kenora, Ontario. Dr. A. Torrie (Personal Communication, November 25, 1984) identified that few physicians refer Indian clients directly to Indian healers. Rather, health care workers restore a person's health to a reasonable state and then refer that individual to the native healer programme for follow-up. Torrie reported that "the results we have seen to date are encouraging". All but one of the six reserves in the Kenora trading area now have some form of traditional healing ceremonies such as the Sweat Lodge (ritual sauna bath). It should be noted that not all Indian people embrace cultural healing practices as they feel there is a conflict between their Christian beliefs and native healing activities.

Meketon (1983) noted that cross referrals and consultations have been occurring between mental health workers with the Indian Health Service and traditional healers in the United States. Problems associated with this practice have been identified. They included: certification of traditional healers for recognition and payment, the issue of whether or not to offer financial compensation for services rendered, and identification of traditional healers. Added to this list of concerns could be issues stemming from a legal and professional

perspective. Who is responsible in terms of liability and accountability? These problems have developed due to the fact that management policies have not been formulated in relation to traditional healers. It is predicted that policy development will be an inevitable process that governmental bodies will have to undertake in the not too distant future.

3.5 INDIAN PEOPLE

It is a recent phenomenon whereby health care consumers are consulted regarding their perceived health needs. This is particularly evident with the Indian People. Local boards of health at the reserve level have been formed to focus upon the health needs of individual communities and to priorize health interventions (Nuttall, 1982). Sophistication and maturation of Indian political expression has significantly contributed to this development. What are Indian People suggesting as input to the health care system in relation to traditional healers and Elders? The major goals identified in the area of traditional medicine are: the need for a closer working relationship between medicine men and physicians; training programs for traditional Indian healers; and orientation of health personnel in the ways of traditional health practices (Jackson, 1980).

The present health system must utilize traditional medicine mechanisms as well as encourage self-reliance and

dignity in the delivery of an essential community service (Starblanket, 1979). For example, traditional healers are often consulted "in preference to, or as an adjunct to, modern medical doctors" (Johnston, 1982, p. 4).

Requests and demands by the Indian people related to health care will have substantial effects upon the health care system. Indian political bodies at the regional, national and international levels are exerting pressures for change on the various systems associated with Indian health care.

3.6 NURSING PROFESSION

Nurses as employees of MSB work within the existing health care system and are subject to the system's philosophies and policies. Nurses also possess the ability to practice independent transcultural nursing concepts. The nursing literature is replete with information related to transcultural nursing. This subfield incorporates the synthesis of knowledge from the area of anthropology and nursing (Leininger, 1984). Numerous nurses have advocated a transcultural approach to nursing clients (Dobson, 1983; Leininger, 1978; Skeet, 1981; Tripp-Reimer, 1983; Tripp-Reimer, Brink & Saunders, 1984), and support the position that cultural factors are an integral part of providing total health care services to clients. Nursing is increasingly encouraging holistic health care and healing,

and is beginning to focus on transcultural and holistic approaches to better patient care (Fulton, 1985; Mardiros, 1986). A new culture of nursing is emerging where effective interactions are based on a knowledge and acceptance of the client's cultural values, beliefs and practices (Cardenas & Lucarz, 1985).

A native American nurse (Primeaux, 1977) proposed that the nurse's attitude of acceptance can influence the utilization of medicine-men. Nurses who have a receptive attitude will gain valuable insights about indigenous health systems (Leininger, 1967). The importance of incorporating the medicine man (traditional healer) into the client's treatment regime where appropriate, was also supported by Richardson (1982) and Fagermoen (1982). The American Nurses Association identified that the ignorance of Indian culture among health professionals and the lack of mental health programs which embody traditional culture, act as obstacles to improving Indian mental health (Ruffin, 1979).

After an exhaustive review of the literature Flaskerud (1982) urged that folk healers be hired as paraprofessionals and serve as consultants to mental health workers. Collaboration between mental health workers and traditional healers was another major recommendation. Collaboration would enable health professionals and traditional healers to make cross referrals on an informed basis. This suggestion was documented by numerous authors (Abad, et al., 1974;

Campbell and Chang, 1973; Kinzie, et al., 1972; Padilla, et al., 1975; Primeaux, 1977b; Ruiz and Langrod, 1976; Snow, 1974; Weclew, 1975; Warner, 1977; in Flaskerud (1982)). A more recent collaborative approach between non-professional healers and the professional health care sector was advocated by Anderson (1985). This nurse identified that healers within the folk sector "may be considered to be more efficacious in treating illness than the Western health care system" (p. 238).

In the Canadian north, the philosophies of transcultural nursing are applied mostly on an individual initiative. Nurses acquire knowledge largely through trial and error (Hodgson, 1980). This trial and error approach has been identified as neither sufficient nor adequate in providing transcultural health care to others (Leininger, 1976). Mardiros (1986) identified that a lack of trained professionals exists, who understand native Indian cultures and languages or the health needs of a rural population. She also advocated that "traditional health care practices must be preserved and strengthened if we [nurses] are to meet the challenges of contemporary health needs" (p. 15).

Scott (1978) documented the use of traditional midwives. She considered it important for nurses to encourage Indian people in their desire to carry on with their traditional methods. In working with diabetic Ojibway clients in Toronto, Hagey and Buller (1983) found that spiritual

leaders may be involved in the treatment regime. They identified the use of the sweat lodge but noted that physicians were reluctant to employ its use for fear of insulin shock due to excessive heat. Little research has been conducted in relation to traditional healing approaches (Leininger, 1981).

In 1975, the Registered Nurses Association of Canadian Indian Ancestry was formed. Among this groups' objectives, was the desire "to conduct studies and maintain reporting, compiling information and publishing material on Indian health, medicine and culture" (Canadian Nurse, 1978, p. 43). The development of research related to cross-cultural nursing and cross-cultural medicine was also proposed.

Additional knowledge and understanding is needed of traditional health systems, if northern (and urban) nurses are to effectively carry out the principles of transcultural nursing when caring for Indian clients. As well, the integration of transcultural principles into all levels of basic nursing education has been identified as the key to adaptive health care (Cardenas & Lucarz, 1985).

3.7 ANTHROPOLOGICAL PERSPECTIVES

Information arising from the discipline of anthropology and medical anthropology presents as input to the systems and subsystems identified. Unfortunately, the concepts related to anthropology have been virtually ignored by the western health system. Western medical systems are finally becoming aware of the importance and significance of the anthropological findings related to traditional healers. Traditional medicine is not a new concept or phenomenon but rather an important and integral part of all human cultures. (Ragan, 1980)

Rappaport and Rappaport (1981) identified that American Indians (amongst other groups) have trouble with the prevailing psychological treatment mode in the United States, due to differences in values, expectancy and the inability of physicians to share the world view of their clients. "These integration problems are raised with the hope of increasing the use of the traditional healer in any context" (p. 779). Worsley (1982) concurred with the findings regarding the world view of scientific healers. He elaborated on this position from the traditional healer's perspective. "The traditional curer possesses an intimate knowledge of the patient's roles and role-sets within the community and a shared understanding of cultural values and social norms" (p. 317). Thus, traditional healers and Elders assume a social perspective towards the client's illness.

Kleinman and Sung (1979) identified that modern medicine addresses the control or treatment of a disease but does not address the meaning for the individual's experience of it. The authors proposed that the lack of concern for the latter has contributed to "patient non-compliance and dissatisfaction, inadequate and poor care, and medical-legal suits" (p. 8). As well, the authors proposed that modern professional health care tends to treat disease (primary malfunctioning in biological and psychological processes) but not illness (the secondary psychosocial and cultural responses to disease). In general, indigenous systems of healing "tend to treat illness, not disease" (p. 8). Horton, in Kleinman and Sung (1979), stated that "scientific medicine is structured to provide technical information, but not personally and socially meaningful explanations [of illness]" (p. 22). Thus, it would appear that personal and social meaning for the experience of being ill is being ignored by the western health care system. The fact that indigenous practitioners are usually exceptional in incorporating psychosocial and cultural factors in their treatment, enhances their credibility as healers.

It has been argued that modern medicine can more effectively serve populations in developing areas by utilizing certain of the resources of indigenous medical systems (Kiev, 1966). The latest health statistics would identify Canada's Indian people as a developing nation

(Indian Affairs and Northern Development, 1980). A specific example was demonstrated by Jilek (1971) where collaboration between western healer and traditional healer provided for the psychological comfort of a patient and the patient's family. This collaboration contributed to a better therapeutic outcome. Kleinman and Sung (1979) stated that traditional healers primarily treat three types of disorders:

1. acute, self-limited (naturally remitting) diseases;
2. non-life threatening, chronic diseases and;
3. secondary somatic manifestation (somatization) of minor psychological disorders and interpersonal problems (p. 24).

Thus, the psychosocial supportive dimension of the traditional healing system has once again been identified. There is a general consensus among anthropologists that traditional therapeutic regimes are remarkedly effective in this area (Foster, 1978). It is interesting to note that Rodgers (1979) also identified Elders as primary therapists in the psychiatric sense and in the psychosomatic illness sense.

A Canadian study by Stymeist (1972) suggested that in order to improve the existing health delivery system, the recognition of the indigenous health system was a priority. He also recommended that "effort should be made to approach

and understand indigenous medical systems with reference to their form and structure as well as their content...this understanding, once achieved, should be part of the training for all doctors and nurses" (p. 275).

The unicultural stance maintained by the Western health care system was also noted by Weidman (1979), who articulated that the orthodox [Western] health care system has assumed a unicultural perspective in relation to the populations for which it is responsible. In order to achieve an optimum level of health for its populations, the orthodox health care organization needs to incorporate "a transcultural perspective on health issues and health/illness related problems" (Weidman, 1979, p. 86). This proposition also received support from Ragan (1980) who advised that "practitioners of modern medicine and students in training also should receive instruction in indigenous systems as appropriate, in order to improve their attitude to them" (p. 44).

When faced with the dominant and powerful Western medical system, traditional healers often go underground. The traditional systems disappear and then experience a revitalization, acceptance and adoption by the population (Landy, 1977). Many of the traditional Indian healing practices have been lost and in some instances Indian healers have been imported into areas in order to resurrect traditional practices. The current revitalization and

renaissance of traditional Indian healing practices lends support to Landy's observations.

3.8 SUMMARY AND CONCLUSION

Social and health services should be provided to people in ways which are culturally acceptable to them and which enhance their sense of ethnic group participation and power (Green, 1982). It is the general consensus that the health demands of Canada's Indian population are not being met by Western medicine (Kennedy, 1984). This finding is extensively documented in the literature and despite the scientific findings regarding the efficacy and effectiveness of traditional Indian healing practices, few programs are in existance which formally embrace or integrate the available medical resources. That is, the professional sector consisting of highly trained medical experts and the existing traditional Indian health beliefs and practices have not been melded into a culturally congenial system for Canada's Indian people.

It is known that Indians augment the health services offered by the Western health care system with resources available to them in the folk sector (Kennedy, 1984). Nurses as primary health care workers are in a position to offer a culturally relevant client treatment milieu through the judicious utilization of and collaboration with traditional healers and Elders. Given the alarming Indian

health statistics and the limited mental health services in the northern setting, collaboration with Indian Elders could offer satisfactory results to both the client and the health care provider. The literature overwhelmingly supported this proposition and thus, it becomes imperative to establish those factors which nurses perceive as influencing their decisions in collaborative efforts with Elders/traditional healers. Collaboration with the non-formal health system needs the approval and support of Medical Services, not just in principle, but in practice. The proposition may appear formidable but is not impossible to implement. The Indian people are utilizing both health systems in their quest for symptom relief. It will be difficult (and indeed may be dangerous) for the health systems to operate in isolation when clients are increasingly participating in both systems.

Chapter IV

METHODOLOGY

4.1 INTRODUCTION

In view of the limited research conducted regarding collaboration between Elders/traditional healers and nursing personnel, this study was at the explorative-descriptive level of inquiry. The purpose of the study was to isolate and identify those perceived factors which influence nursing personnel in the collaborative process with Elders. The conceptual framework provided the infrastructure for the research design. External and internal factors previously identified and defined in the conceptual framework were explored in detail through the research process. The research design consisted of two phases.

4.2 FIELD INTERVIEWS WITH NURSES/ELDERS: PHASE I

This phase of the research process was employed to provide a preliminary, exploratory data base upon which subsequent research could be developed. Information gained during this phase guided the selection of questions for a structured questionnaire which was administered to subjects in Phase II. As recommended by Glaser and Strauss (1966),

this research phase was scrutinized for its usefulness as an end product. An absence of research was noted in this particular area of nursing and consequently, the research approach implemented was an adequate and efficient method.

Three Indian reservations in northern Manitoba were identified by key Indian informants as being active in traditional Indian medicine. In order to protect the nursing staff and Elders who were asked to participate in this research phase, the reservations have been identified as A, B, and C. An open ended interview (See Appendix A) was administered to the nursing personnel at each reserve. There were 10 nurses directly involved in this phase. The purpose of these interviews was to permit nurses to share their transcultural nursing experiences and contact with the traditional health care system. Perceived factors affecting collaboration with Elders for the purpose of client counselling were also obtained from this data source.

An open ended interview (See Appendix B) was presented to the Elders of reserves A, B, and C. The Elders were selected by the Chief and Council on each reserve respectively. The purpose of the interviews was to permit the Elders to offer information related to their requested participation in the counselling of patients. The interviews also permitted the Elders/traditional healers to share their experiences and contacts with the non-traditional health care system. Thirteen Elder interviews

were conducted and approximately 3 days were spent in each location (reserves A,B,C).

Nurses and Elders have been identified as target comparison groups. The use of comparison groups during this research phase maximized Phase I credibility. Glaser and Strauss stated that the strategy of analyzing comparison groups helps to "generate the speedy development of analysis by drawing the observer's attention to many similarities and differences among groups" (Glaser & Strauss, 1966, p.58). In terms of ethnomedicinal practices, nurses and Elders were at opposite ends of the continuum and therefore, similarities and differences in the factors affecting collaborative efforts between the comparison groups became readily evident.

4.2.1 Subjects

The target nursing population identified consisted of Medical Services nurses possessing autonomy (that is, the ability to initiate independent client treatment regimes, or client treatment regimes based on inter-professional collaboration) in the active treatment of Indian clients in the province of Manitoba. The target Elder population consisted of those Elders identified by the Chief and Council on the various (A, B, C) reserves. The selection of Elders by the Chief and Council is suggested as a reasonable and prudent method of obtaining participants. The

identification of the Elders was a task which the investigator was not able to complete without spending considerable time in the various Indian communities. Given the financial and time constraints associated with this research effort, the Chiefs were asked to assume responsibility for the selection of Elders.

4.3 SURVEY MAIL QUESTIONNAIRE: PHASE II

Data collected and compiled from Phase I was instrumental in developing a survey mail questionnaire which was implemented in Phase II of the research process. This questionnaire was distributed to nursing personnel active in the care of Indian clients on reserves and health centres in Manitoba. The purpose of the questionnaire was to identify nurses' perceived factors influencing collaboration with Elders. The questionnaire also explored the extent of nurse-traditional healer contact.

4.3.1 Subjects

The target population consisted of Medical Services' nurses who possessed autonomy in the active treatment of Indian clients within the province of Manitoba. A complete census survey of the entire target population (Medical Services nurses) was implemented. A description of the study subjects follows:

NORTH ZONE

1. Ten (10) Nursing Stations: 32 nurses
2. One (1) Health Centre: 3 nurses
3. One (1) Band Health Centre: 1 nurse

SOUTH ZONE

1. Eight (8) Nursing Stations: 23 nurses
2. Eight (8) Health Centres: 12 nurses
3. Four (4) Band Health Centres: 7 nurses

Nurses working in Medical Services Hospitals (N=18) were excluded due to the differences of autonomy in the treatment/care of clients. Zone Nursing Officers (N=6) were excluded due to their limited active patient care. As well, those nurses involved in Phase I research were excluded due to possible sensitization (N=10). The above figures represent the total possible number of nurse positions in north and south zones. The actual number of Phase II study subjects was N=64.

4.4 DATA COLLECTION TECHNIQUE

4.4.1 Field Interviews With Nurses/Elders: Phase I

Prior to data collection, approval was received from the following agencies and individuals:

1. The Ethical Review Committee of the University of Manitoba.
2. The Regional Director, Medical Services Branch, Manitoba Region.
3. The Indian Chiefs and Councils of Reserves A, B, and C.

Data from the field interviews were collected through the employment of open ended, semi-structured, face to face interviews. The consent form and interview schedule were forwarded to the subjects one week prior to the investigator's arrival. The interviews were tape recorded to permit accurate recall of information and were completed in approximately 30 to 60 minutes. This direct recording applied to the nurses. It was anticipated that a translator would be necessary for interviewing some of the Indian Elders and consequently, the translators and not the Elders were recorded directly. Exceptions were made for those Elders who were able to converse in English. The tapes were destroyed immediately following transcription of the data. Four of the Elders did not consent to have their conversations tape-recorded and hand written field notes were made during these interviews. Remuneration was offered to the translators for professional services rendered and the translators were asked to consider the interviews confidential.

The quality of several Elder interviews was to a great extent dependent upon the expertise of the translators. One of the translators recently returned from the First Minister's Conference in Ottawa where he assisted with translation services. The second translator was a teacher by profession while the third translator was a community health representative (CHR). The translators were of a high calibre and the investigator was fortunate to be able to employ their services.

Additional demographic and personal data was obtained at the time of the interview. (Consult Appendices A, B, for data collected.) This information was included to account for other related factors which may have implications for this study. For example, there are nurses employed in the north who are not Canadian citizens and have been subjected to different cultural and educational experiences. These experiences may or may not have included transcultural nursing concepts and principles and consequently may influence decisions to collaborate with Indian Elders. The interview schedules developed were presented to nursing and anthropology experts in order to establish their validity in terms of the focus of this study.

4.4.2 Survey Mail Questionnaire: Phase II

Collection of data in this research phase was accomplished through the employment of a closed, structured mail questionnaire administered to the identified census population. Demographic information also constituted part of this questionnaire. The questionnaire was submitted to fellow nurse colleagues (N=5) for review prior to implementation and was also submitted to the Ethical Review Committee for scrutiny.

4.5 ETHICAL CONSIDERATIONS

The protection of individual rights was addressed through the provision of consent forms, the provision of measures addressing confidentiality, Band Council permission to approach Elders as possible research subjects, and approval from Medical Services to approach their nurses as study subjects. All research subjects (except Phase II nurses) signed a consent form outlining:

1. the purpose of the study;
2. the voluntary nature of the study;
3. assurance of confidentiality;
4. the ability to withdraw from the study at any time;
5. the availability of the results to participants upon request.

Consent forms were developed to ensure the protection of subject rights. The consent form for the nurses was published in English and the Elder's consent form was published in Cree syllabics and English. The consent form for Elders was required to be translated orally into Cree on three occasions because the Elders were unable to read and understand Cree syllabics or English. The gist of the consent form was explained by the translator and was signed by the Elder.

Three separate consent forms were developed due to the nature of the research methods to be employed and the subjects involved. Cover letters and consent forms that were forwarded to the members of the various research groups were identical in format and content. The consent forms were as follows:

1. Phase I: Nurses-Appendix C
2. Phase I: Elders-Appendix D
3. Phase I: Elders-Appendix E (Cree Syllabics)

All collected data was held in strict confidence and was prudently secured. Tapes were destroyed after transcription and information that could have identified subjects was coded, with access to this coded information limited to the principal investigator.

Individuals, specific groups and locations will not be identifiable in published materials. Written permission

will be obtained from research subjects prior to release of any information or publication of any material that would identify specific individuals, groups or locations. Medical Services will receive published results only and collected raw data will not be available to this organization.

4.6 LIMITATIONS OF THE STUDY

There were limitations inherent to the nature of this proposed research design and methodology. The limitations identified were as follows:

4.6.1 Language Barrier

There is always a potential for misunderstandings when communication is not direct between investigator and the research subject. It is hoped that the research questions and subsequent responses were transferred without undue alterations in subject content. As previously mentioned, the calibre of the translators was more than satisfactory. This limitation is directed specifically towards the investigator who was not able to speak the local Indian language. Because of the investigator's language deficit, it became necessary to employ translators.

4.6.2 Elder Selection and Numbers

The selection of the Elders (N=13) was the responsibility of the Chiefs and Councils. The limited number of Elders solicited from each reserve may have influenced the manner in which the Elders were identified. The Chiefs and Councils were requested to simply identify 3-4 Elders from their communities, and the actual mode for Elder selection was not formally made known to the investigator. This judgment sample will have to be viewed with caution as the small sample size of Elders limits generalizations.

4.6.3 Exclusion of Phase I Nurses From Survey Questionnaire

The exclusion of the nurses who participated in the field interviews (N=10) may have eliminated valuable data or biased the results in a conservative direction. These nurses were identified as working in communities active in traditional Indian medicine and it is suggested that the statistics reflecting interaction between the nurses and Elders may have been augmented had these particular nurses been included in the population sample.

Chapter V

EXAMPLES OF INTERACTION BETWEEN TRADITIONAL HEALERS AND PHASE I NURSES

This chapter documents several interactive and in certain cases, collaborative efforts between nurses and Elders/healers. The information was obtained from field interviews with nursing personnel (N=10), working in three northern Indian communities active in traditional Indian medicine. Information in this section on traditional cures was also obtained from field interviews conducted with Elders/healers (N=13).

The following cases illustrated the fact that Indian people were utilizing both health systems in order to procure relief from their health problems. The cases also demonstrated that the Indian people were sharing their experiences of the traditional system with the nurses. Nurses in the three locations chosen for this study were informed of this shopping behaviour by the patients themselves. The Indian people were comfortable in utilizing either system in their quest for successful treatment. It was demonstrated that symptom relief obtained in one system negated the need to procure services in the other health care system.

Cross referrals between the traditional healers and nurses were also documented in this section and several cases identified the respect and faith held by the nurses with regards to the alternate healing system. A few nurses acknowledged the effectiveness and efficaciousness of Indian medicine.

> I find that I would have no hesitation in dealing with it [traditional healing practices] because I come from a background where I know of traditional healing. It's quite important to many people and it generally works.

> We had one lady here who used to have fainting spells, and her family would bring her to the nursing station and she would wake up about five minutes after she got here and say, "I'm here again. I told them not to bring me. I told them it was a curse. There's nothing you can do. The medicine lady told me that I had a curse on me for two years. I would faint every month or more often, and I could see every doctor in Thompson and Winnipeg and they would never find anything wrong with me. At the end of two years I will be better." And she was right. How much of that is her own psychological beliefs and how much of it she has actually been hexed, I don't know. Their medicine is very powerful.

CASE 1

> There was a kid who was not responding to our standard treatment for infected impetigo. And you know, we had done clox [cloxacillin, an antibiotic] and the whole bit and it seemed to get worse. And I was aware of [traditional healer] and I said to the mother, maybe [traditional healer] could help you with this. Maybe he's got something that we don't have. And, do you know, he did. I went there two days later. This healer had taken the child's hair off and covered his head in what I thought was axle grease and just left the kid. And whatever it was, after about a week the impetigo had gone. It had cleared up. His skin was absolutely clear and his hair was growing again. But, I never had the presence of mind then, because I didn't know him well enough to ask him what he used.

The nurse is this case was also invited to the traditional healer's residence to view his collection of herbs, roots, and medicines. A sincere interest and appreciation of the alternate health system was displayed by this particular nurse. This nurse expressed that she had no difficulty in collaborating with the local healers and in fact had collaborated with them on several occasions.

CASE 2

> There was a man suffering from very severe headaches for quite a long time and had everything done in Thompson and Winnipeg, including a CAT scan and nothing was found at all. We never saw him in complete distress the other people saw him in. We would get a telephone call that he was rolling on the floor in pain. So we would say, bring him in. When he got up here, he just sat and looked at us. After the CAT scan when he was sent back here, we tried to explain to him that nothing has been found and he put in a request to see a traditional healer. We told him to go ahead and make the arrangements through the routine way. And then he came up to see me a couple of days later requesting repeat of the pills the Dr. in Thompson had given him. While I was doing that, his niece mentioned that his neck was very painful

> as well. And when I examined him, the muscles from his neck up into the back of his head were rigid. I started him on Robaxin [muscle relaxant] and the headache disappeared, and he cancelled his request for a medicine man and was very happy.

CASE 3

> We had a lady who told me once that the medicine man gave her something for her menopause symptoms. She received relief from her symptoms for about two months. I said that she should go to him then, instead of taking these drugs that who knows what they are doing to you.

Case 2 demonstrated that symptom relief obtained in one health system negated the need for further treatment in the alternate system. In Cases 3 and 4, the patients shared with the nurses, the fact that they were utilizing both health care systems. The nurses accepted this behaviour and encouraged the patients to utilize whichever system provided the greatest relief for their health problems. Both of these nurses were active in direct patient referrals to traditional healers.

CASE 4

> Like people will come to me and say, "The medicine man helped me with this!" So I say, well go to him again...because I don't know. I believe like a lot of them, for months on end, they are fine with what he has given them. And then they come here and want to try ours again. The odd one will do that and I'll say, well if it worked and you believe it works, then go. I don't always believe in our medicine either.

CASE 5

> We had a man who was dying here this July and his son was really not prepared for this at all. He had terminal cancer and it went very fast. So right away they went to a traditional healer. The son came here one day and he said, "You are not helping my dad at all." And I said, you knew right from the start that he refused treatment for a long time and on and on like this and he said, "Well I've gone to the medicine man and he's telling me what to do." Something about a crow eating a crow and it drives out the spirits or something. I said to him, go try it but don't have your hopes up. He did it and he said his dad felt better, but within a week his dad had died.

The next case involved a young boy aged 15 who was brought to the nursing station in an unresponsive state. The nurses and family contacted the medicine woman and had her brought to the nursing station to assist with the patient. The nurses recognized that the treatment for this patient was within the realm of the traditional healer.

CASE 6

> The child, he's 15, was brought in unconscious and unresponsive, although he would react to extremely painful stimuli. And he was unconscious for about two hours and the family kept phoning us and saying, "Has he got a pink ribbon on his arm?", and "Has he got a red ribbon around his neck?". And all this stuff. It was about this time that I began to twitch that there was something going on that wasn't supposed to be. It took about an hour for the family to get in. And they wouldn't really talk about it, but one brother told me that there was nothing we could do for him. He said it was out of our hands. I said, "Is he in the hands of the medicine lady or the medicine man?" And he said, "Something evil has happened to him", and that's all he would say. We eventually got the medicine lady who came in to talk to him. The family felt that someone had put a hex on him.

One of the nurses identified this medicine woman as a professional and advocated a collaborative approach in assisting clients and patients with their health care needs. The medicine woman's skills and abilities were acknowledged and praised by this particular nurse. The adjectives used by the nurse to describe the medicine woman were "sophisticated" and "professional". This nurse also identified a need to communicate with the traditional healers.

> She [medicine woman] came here to the nursing station and saw the patient and decided that he would need many more treatments. We have a good medicine lady here. She's sophisticated enough to work with the nurses. You almost feel that you are dealing with a professional. What I did also too, the first day I saw her in the station, I got one of CHRs and told her that I wanted her to know that I recognized her profession also, and I know we both are doing the same thing. And I hoped we would be able to work together. They need to understand we recognize that they have abilities and skills too.

The next case illustrated a positive health outcome resulting from a combination of the two health care systems. The medicine man supported the findings of the nurses and helped the patient and family to accept the dominant health care system's diagnosis and treatment. The traditional healer in this instance was an asset to the dominant health care system and the two systems worked harmoniously and complemented each other. The dominant health care system was unable to provide relief for the patient and therefore consultation with the traditional healer was initiated by the patient's family.

CASE 7

> We had a young girl 12 years old who was coming into the station continuously with chest pain and many other things. We examined her completely and couldn't find anything. We sent her into Dr. [Thompson physician] who examined her from head to toe, including total body x-rays because she had aches everywhere. He couldn't find anything at all. We decided in collaboration that she was probably just trying to avoid school. As a prenote, the problem started when she started to menstruate for the first time out on the trapline. For a lot of girls its a big shock, but starting to menstruate out on the trapline was probably quite a shock to her. Her family decided that if we weren't going to do anything for her, they were going to take her to a medicine man in [location]. The medicine man told her that it was all in her head, and that she should pull herself together and start helping other people and forgetting herself, and that was a direct quote from her uncle who had been told by her father or mother. We hadn't referred her because it had never occurred to me to do so in this particular case, but it did work out. Everything the medicine man said supported what we had already said.

Case 8 demonstrated a negative result of an interaction with a traditional healer. This was the only negative intervention discussed by the nurses interviewed.

CASE 8

> We had a very famous medicine man from Alberta, and he was here for a week in July. And to a certain extent, he did a lot of damage in that anyone who goes to the medicine man is not allowed to use the white man's medicine, while they are seeing him. But we had a few people here who are quite hypertensive and on apresoline and things like that, that should not be stopped dead. And we had one patient who went to see the Indian medicine man who told him to stop all his medication...like now. If he does not feel better in one week, he's to come back to the nursing station. So in that way he did refer him back to

> us if his medicine didn't work. But by the time he did come back, his blood pressure was in the clouds. In fact, we had to send him out to Thompson.

The traditional healer requested the patient to consult with the nurses should he not feel better within a week. This situation could have escalated into a most serious scenario, with the patient's health and possibly life placed in jeopardy. Informing the traditional healer about the potency of this particular drug could have possibly enabled a different treatment regime to be initiated. The patient could have been monitored by the nursing staff and appropriate interventions initiated prior to a crisis situation. The importance of dialogue between the traditional healers and the nurses becomes clear. The Indian people are utilizing both health systems and one health system cannot ignore nor deny the presence of the other system. The Indian health system is not going to disappear. A complimentary approach between the two systems would benefit the Indian people, who are the utilizers of the systems, and for whose presence the two systems exist.

5.1 EXAMPLES OF TRADITIONAL CURES

Several of the traditional healers shared particular cures for specific health disorders. Not all of the cures will be presented out of respect for the healers and the trust they displayed to the investigator.

5.1.1 Dreams and Cures

One traditional healer was identified as a dream interpreter based on the analysis of the following transcript.

> Sometimes in a dream you know, maybe your mother or maybe your father, or one of your relatives did something that falls on you. And you get sick on that. And you go to the nursing station and you go to the doctor and nothing, nothing helps you. But if you go to the medicine man, he will know how this happened to you. I'll tell you about myself. Poor Joe's wife, she was living here. She had a lot of children you know. And, she was choking every time. She got sick on that for many years. She went to the hospital, she went to the doctor. She went to everybody she could think of. So one day, I guess she was pretty sick and maybe someone told her something about me...so she asked me to come over. She says that she couldn't breathe. So I said, OK. The first what I'll do is I'll give you some snow. And I went out and took a cup and put the snow in there. I put it on a white cloth. It's got to be sacred. So I put it there, let it melt until it's melted. And you won't find too much water in there...but you drink that. She says OK. She drank that and the next morning I went and seen her. And I told her in a dream that in the past her father, they were keeping an old guy, an old, old man. And I guess they were tired of that old man...that old guy. Took a string and choked that old man and put him in a pit. That's where they put the old man you see, but he wasn't dead yet. He was still wearing that string. That's in the past before the laws came around. So I told the old lady...that's what I see. I can see a man wrapped up in a tarp. So one of their people that was living at the time, they heard about it, and once somebody tells you about it, you know, that person cures right at the same time. I told her the next time if you're like that you'll be gone for good. You can only do that once to a person. That's it. That's what I done.

This client initially sought relief from her symptoms through the dominant health care system. When this strategy proved to be ineffective, she contacted this healer who

offered her relief. The client was comfortable in utilizing both health care systems in her search for symptom relief. This pattern repeatedly surfaced in the data. The fact that Indian people are utilizing both health systems lends credibility to the recommendation of collaborative and/or complimentary efforts between the two systems.

5.1.2 Seneca Root

This next Elder was keen on educating the nurses about Indian medicine itself. He felt that by identifying the medicines, the nurses would utilize them. His rationale was that the Indian medicine would offer relief to the patients more quickly then the White medicine, and therefore the nurses would logically make use of the Indian medicine.

> Maybe if they know about these medicines...what the people are using...that the Elders are helping this man to get well faster than what the nurses are giving. I think they should have the right to know what it looks like, what it is...Like using seneca root. You take this seneca root here in the north in the water. You see, you pull it out, and then you wash it. It's got lots of little legs, but you scrape these out and just keep the root. And then dry it up. That thing will never spoil. You can use it and keep it all winter. You can use it, it doesn't matter how hard it is. You can pound it into a powder and use that...drink it. And there's other kinds of herbs that they use that you can put in your tea.

5.2 CONCLUSION

It was evident from the data collected that serveral nurses were in direct contact with various members of the traditional health care system. It should be noted that this contact resulted from a personal interest and appreciation of the traditional healing system on the part of the nurse, and not as a result of official Medical Services policy.

Nurses who demonstrated an interest and appreciation for the traditional healing system were entrusted with information related to the non-formal health care system. The case studies identified the use of both health care systems by the Indian people. This behaviour has significant ramifications for health care providers active in the care and treatment of Indian clients. Denying the potency of the traditional health care system undermines any attempts by the Native People to develop and preserve their own health care modes. The utilization of both health care systems by the Indian people supports the need for recognition of the non-formal health care system and indeed, supports the need for integrative approaches to the provision of native health care.

Chapter VI

FIELD INTERVIEWS WITH INDIAN ELDERS

6.1 INTRODUCTION

Data for Phase I (Field interviews with nurses and Elders) were collected through semi-structured, face to face interviews conducted in three northern Manitoban communities. The actual location of the Indian reservations remain unidentified to protect the anonymity of the research subjects and communities. The reservations were chosen as a result of information provided by reliable Indian informants who identified the communities as being active in traditional Indian medicine.

The Chiefs and Councils were requested by the investigator to identify three to four Elders in their communities. This judgment sampling of Elders served as a consultant group and it is not known whether the small number of Elders from each of the reserves constituted a significant sample of the Elder population.

Of the thirteen Elders identified by the Chiefs and Councils, one was a medicine woman, four Elders were medicine men, and one Elder was identified as a dream interpreter after the interview. The remaining seven

research subjects did not identify themselves as healers, nor did they offer information which would allow this status to be ascribed. Translator services were required for eight of the Elder interviews and each community provided their own translator. Four of the Elders did not consent to have their conversations tape-recorded and hand written field notes were made at these interviews.

6.2 SOCIAL ROLE AND FUNCTION OF THE ELDERS

Nine Elders replied that their people consulted them for help. The word "help" was not defined for the Elders. It was offered undefined in the interview question to enable the Elders to identify how they interpreted this word. The following examples illustrate the type of assistance or help the Elders were offering to their people.

6.2.1 Counselling

> Everyday people come to her for help. She gives counselling to people in regards to alcohol and abuse of solvents.
>
> Yeah...and I'm trying to counsel them and tell them what they should do.

6.2.2 Indian Medicine

> They come mostly for medicine.
>
> A lot come for help and Indian medicine.
>
> A lot of people come to him for help. Sometimes people come to him with Bell's Palsy; he can treat the people for that.

Sometimes a few people come to him for help and for Indian medicine.

6.2.3 School Children

He says a lot of times he goes to Thompson in the fall and he goes to the schools and they have a program called Native Awareness Week. He attends these workshops with the students. And he talks about the past, and stories about the past, also medicine and he shows the medicine, what they are used for and what the purpose of the medicines are.

6.2.4 Domestic Advice

He says the most people he helps is the people that come to him. He helps them by ways of talking to them so they can understand life better in the long run.

Yes, when they have family problems, they used to come to me. And I used to try and help them some way.

Like my children or somebody else. I talk to my children when they have family trouble.

They come for advice about welfare and home-makers.

It was interesting to note that the majority of the Elders described a precise and well defined role in terms of what help they could offer to their people. Two major themes emerged:

1. Counselling/Advice.

2. Historical Information/Perspective.

6.2.5 Counselling/Advice

The young people of the community were identified as the likely candidates for advice and counselling services. In fact, the Elders seemed to address their interventions specifically to the youth. Counselling in the schools was mentioned by several Elders (N=3).

> Oh yes...these young people, they need to have some kind of organization. Just lately they were trying to have this young people's group. They should ask one of the Elders, or maybe three or four Elders to counsel. To tell them how they should be acting.
>
> She can really give them advice if they come and ask her for help.
>
> They can give advice to children in the community or in the schools. They used to do that. They used to come and get the Elders to go to the school and help the children...but not anymore. Now they never bother to ask for his advice.
>
> He says he always talks to his children about alcohol and alcoholism. The counsellors come here and ask him to talk to the people about that.
>
> There are some...who went into the school this last year maybe half a dozen times...telling stories about animals and our livelihood in the past. I went. I helped them.

6.2.6 Historical Information

The Elders stated that they could let the people (especially the children) know what things were like in the past. Legends and folklore were also identified as important subjects to be shared with the people.

> She could tell them what the people used to do long ago...like how they used to live long ago.

> The only thing that the Elders can do is what they have known in the past...what happened and how they got along. There is little they can explain except for domestic living. They can do that.
>
> The Elders can give advice and they could also tell them how they used to live and how they were raised. There is a lot of difference now the way the people are living compared to how the people used to live.
>
> I myself as an Elder would be pleased to help the people in the community with whatever I could do. To go around and talk to the people and tell them how they used to live a long time ago.

One Elder suggested that Elders could not assist the young people. This Elder indicated that fundamental social changes had taken place in his community, which significantly limited his role and function.

> Elders can't do anything for young people. They don't take advice from the Elders. It's not like long ago. Today he [the Elder] is still following the advice he received from his parents and his Elders.

The nurses in Phase I identified Elders as role models. The Elders have also identified this function through their interests in the youth of the community. Elders served as a link to the past and were important sources of historical information. The role of counsellor also received support from the Elders. The nurse and Elder interviews offered consistent and similar images of the role/function of Elders. There appeared to be consensus of what roles Elders could perform (nurse's perspective), and what Elders actually perform (Elder's perspective).

6.3 RESPECT FOR ELDERS BY THE INDIAN YOUTH

Seven Elders emphatically stated "yes", the young people respected them. Two Elders said "some", while one Elder identified that the youth did not have respect for the Elders.

> Well, some of the young people, they're playful you know. They don't want to disrespect the Elders, but they are playful. You might find an odd one here and there that might not respect anybody. On the whole they respect the older people.
>
> Yes...quite a bit. I can say this. There's very few in fact that the...very few young people will not show their respect to the Elders.
>
> Yes...the young people have a lot of respect for me.
>
> No...I don't think so she said. [Why?] They think they know everything.

6.4 IDENTIFICATION OF ELDERS

All of the Elders stated that it was important for the nurses to know who the Elders were in the community. The reasons for disseminating this information were not as distinct. Several Elders indicated that they could provide the nurses with relevant community information.

> Yes. She said it is very important for the Elders to be known, especially in [location], based on their know-how from back, from beyond, what they have experienced in life.
>
> Maybe they could give them advice or ask what happened long ago.

> I guess...if the nurses knew the Elders, they could tell them what they used to do long ago...she says this is the reason why they should know the Elders.

Two other reasons offered included:

1. To decide who needs home-maker services.
2. Home visits by the nurses to make sure the Elders are in good health.

6.5 INFORMING THE NURSES ABOUT MEDICINE PEOPLE

Nine Elders were asked whether it was a good thing to let the nurses know who the medicine men and women were in the community. Of this number, eight stated that "yes", it was good to inform the nurses. One Elder suggested that it was not a good idea. The reasons for informing the nurses were as follows:

1. Cross Referrals: If the patient was not getting better then the nurse could refer him/her to the traditional healer for treatment.

> Well of course! The thing is you know, sometimes you send a person to the nursing station and they try their best to try and cure that person. But there is something wrong in there...in the human person. If they can't do nothin, they'll send that person back to the medicine man and that medicine man may help somehow.
>
> It would be nice if the nurses know who the medicine men and women are because if one type of medicine didn't work, then the person could be referred to the other healer. I refer people to the nurses. I give roots and if it doesn't work, go to the nurses.

> It is important to know about these medicine men and women in the community because if there is something that the nurse can't cure, maybe Indian medicine can help with the patient.

The concept of cross referrals was readily embraced by the traditional healers/Elders. Combining the two health care systems to the benefit of the patient was a sophisticated proposal advocated by the Elders.

2. The Indian people have faith in, and are actively utilizing the traditional healing system.

> If a person if really sick, he can try the nurse...the white man medicine with the nurse first and if the nurse can't cure him, he can go to the Indian medicine.

> Some people believe more in the Indian medicine rather than the white man medicine, especially the elderly.

> It's good to let the nurses know who the medicine men are to the nurses and even the visiting doctor. [Why?] Because some of the Native people prefer the Indian medicine.

One traditional healer mentioned that the healers in his community were frightened to share their identities because of past retributions against the medicine man and the fear of persecution was still present with this particular Elder. Despite this fear, he encouraged the traditional healers to inform the nurses as to their identities.

> Well these people are scared to tell something like that cause...long ago they used to get after them. Put them in jail...That's why they are scared to say they are medicine people. They

> should tell though, maybe it could help some other people.

One Elder stated that the nurses should confine themselves to their matters, and the healers would do the same. This was the only Elder who identified that no communication or sharing should take place between the two health care systems.

> He doesn't think it's a good thing to let the nurses know who the medicine man is. [Why?] It's his business, if he want to treat the patients. It's his business and the nurse can do his own.

6.6 COMBINING INDIAN AND WHITE-MAN MEDICINE

The question, "Would a combination of Indian and White medicine be a good or bad thing", was posed to eleven of the Elders. Of that number, nine stated that the medicines could definitely not be combined.

> No, it's not good. I guess the Indian medicine man asks if you are using the white man's medicine and if the patient says yes, he won't use the Indian medicine. You have to wait for three days.

> No, it's not good to combine both Indian and White medicine at the same time. Because Indian medicine can help. If the person combines the two types of medicine, they will get sick. They will get worse.

The possible consequences of combining the medicines ranged from inactivating the Indian medicine to death of the patient.

> Well, that's one thing that you can't make it go together. It's got to be parallel lines like. When you are taking pills and somebody asks you to

> give me Indian medicine...that won't work for a while unless you stop taking them pills or the White man's medicine. But if you just take the Indian medicine for a few days or a couple of times, you start to feel a little different. But you can't use them at the same time, you know. They can go wrong. They can damage the person, they can kill a person even. It's got to be a little separate, a little bit.
>
> No...you can't combine the two together. Because if you take the White man's medicine and the Indian medicine, the Indian medicine won't work. You can't combine the two together.
>
> It's no good to combine the Indian and white man's medicine. If you use the White man medicine with the Indian medicine, the Indian medicine won't work.

Two traditional healers stated that a mixture of the two medicines was allowed, as long as the White medicine was not potent. They maintained however, that caution was needed and they were not entirely sure of the consequences.

> Basically she says she sort of wonders about that because she takes aspirin and other things, but she doesn't know about a higher quantity of White medicine. She doesn't really encounter that status yet...but in a way...it's basically either. You take one or not.
>
> Ginger root...that doesn't harm anybody. If you are sweating you know. And if you haven't got nothin else. If you take that...in hot water, tea, or anything hot, then you will be fine. No matter if you have used...ah...some kind of medicine or pills...that won't hurt you. Some of these very odd things can match a little bit together.

Some of the White-man medicine was acknowledged as being effective by the Elders.

> Not all White man medicine is bad. Some work good and some work bad...the White medicine way.

> If you know how to use the Indian medicine, it will work better than the White man medicine, but some White man medicine works better than Indian medicine.

Two of the Elders stated that Indian medicine was better for certain disorders. For example, "ear" and "throat" infections were identified as being more treatable with Indian medicine. It was the investigator's work experience that chronic ear infections and throat infections were very common among Indian clients in the north. Repeated visits to the nursing station to receive a pot-pourri of medications may contribute to the view that White medicine is somewhat ineffective for certain disorders.

> There are some diseases that Indian medicine is better for the people to use. Elders know that it's better for them to use this Indian medicine than asking the nurse for medicine.
>
> She says, from her point of view, a lot of nurses have come to her. A lot of people want this Indian medicine because some of the younger generation such as kids, you know, the nurses come with them on the basis of they cannot cure...sometimes the teeth, the ears, and the throat and this is where a lot of referrals come to her.

6.7 HOW A NURSE SHOULD ASK ELDERS FOR HELP

The Elders defined a specific process in requesting help from them.

> I guess the nurse calls the Elders to the nursing station and asks them for advice or something.
>
> Well they have to...ask the Elder to come to the nursing station and explain over there. The nurse won't go and ask the Elder at his home. If the

> Elders are asked to go to the station, they would probably go.

Opening up the lines of communication between nurses and Elders was identified as an important strategy and a prerequisite in order for collaborative efforts to transpire.

> Well, they should start talkin together like this, you know. Like...to work more closely together and to know what your ideas are. It's the only way they can work together is to communicate.
>
> A nurse should talk to an Elder so he or she could give advice to whoever the nurse wants the Elder to see.

The necessity of ongoing and active communication with the nurses was established through the Elder interviews.

6.8 WHY SOME NURSES ASK FOR HELP

The question, "Why do some nurses ask Elders for help and some do not?" was employed to elicit from the Elders their perspectives on why some nurses approach them for assistance. One Elder interpreted this question in relation to her line of work, healing.

> She feels that some of the patients are referred to her because some of the illnesses that go around, they [the nurses] don't know about. They don't know how to treat the patient and that's why they are referred to her.

This medicine lady indicated that nurses asked her for assistance because of their inability to treat certain disorders. Patients were referred to her because she was able to treat them.

Several Phase I nurses (N=3) identified that the Elder's attitude towards them affected the collaborative process. A parallel situation existed with the Elders, where a negative attitude held by the nurses was viewed as inhibiting the collaborative or interactive process.

> Some of these nurses are not really interested, you know. They are too proud to be with you. A little too high...because you are an Indian and you don't know nothin. They know too much. That's why they don't want you to tell them anything.

> Some of these nurses think that they know everything and they don't need Elders. But some don't. Some depend on people and these nurses that depend on people and ask them for help, the people turns around and likes the nurse.

This latter Elder identified that nurses who seek assistance from the local people are embraced and more readily accepted by the community members. By asking for help, the nurses were viewed positively and as possessing an interest and concern for the information that the Elders had to offer.

It should be noted that seven of the Elders were unable to provide an answer, either through misunderstanding of the question or because they did not care to comment.

6.9 NURSES REQUESTS FOR ASSISTANCE

Of the eleven Elders who were asked whether the nurses ever requested help with some of their patients, ten stated "no". The Elders commented that some of the nurses had at one time asked them questions about Indian medicine.

> The nurses have only asked her to show them the Indian medicine.
>
> They asked her once when she was in the hospital... the nurses asked her how the Indian medicine worked.

Two Elders stated that they were asked for help long ago by the nurses. The nurses asked one Elder for assistance with maternity patients. This Elder was probably one of the community midwives.

> Well...in my younger days I used to help them deliver babies ah...for I don't know for how many years. I volunteered for that.
>
> She said a long time ago the nurses used to come around and ask her for help. But now...they don't even bother.

Nurses who do not rely on the local people for assistance (of any kind) were viewed by the Elders as being "too proud", or "too high", to request their advice or assistance.

6.10 SUMMARY AND CONCLUSION

The field interviews with the Indian Elders yielded rich and valuable data. Included in this data was the identification of the social role and function of Elders. The research subjects suggested the following Elder roles:

1. Counsellors/Advisors: The Elders were frequently contacted to provide counselling and advice to various members of the community. Those members who

were benefiting from this Elder role included: school children, families (domestic advice) and the youth of the community. Elders were active in their communities in terms of providing counselling/advice to community members.

2. Guardians of Historical Information/Perspectives: The Elders identified themselves as sources of historical information. They were providing their people (especially the children within the school setting) with important cultural information. Legends and folklore were identified as areas where the Elders could provide specific cultural information. Elders served as a primary link to the past and offered their people valuable knowledge related to the preservation of culture and survival of the Indian people.
3. Providers of Indian Medicine: Several (46%) of the Elders identified themselves as healers and were active in the provision of direct patient/client health care. Members of the Indian communities were seeking health care from many of their Elders.

It was suggested that nurses need to know who the Elders are in their communities. Moreover, the Elders highly supported informing the nurses as to the identities of those Elders who were healers. The sophisticated concept of cross-referrals was identified by the Elders as one reason

for informing the nurses about the community healers. The Elders readily embraced and supported this concept and proposed that clients/patients who did not receive relief from their symptoms in the dominant health care system would benefit from consultation with traditional healers. The nurses could refer clients to the community healers when warranted.

Identifying community healers to the nurses received support because Indian people have faith in and are actively utilizing the traditional healing system. The Elders identified that many of their people made use of both health care systems. The effectiveness of Indian medicine, specifically in relation to ear and throat infections received support from the Elders/healers.

The combination of Indian and White man medicine was not supported by the majority of the Elders. The possible consequences of combining the medicines ranged from inactivating the Indian medicine to death of the patient. Two healers stated that a mixture of the two medicines was allowed, as long the White medicine was not overly potent. They maintained however, that caution was needed as well as thorough consultation with the healers.

The Elders identified a specific process in terms of nurses requesting help from them. Nurses were advised to contact the Elder in his/her home and then ask this

individual to come to the nursing station/health centre and possibly assist with the patient/client. The initiation of communication as well as active and ongoing communication between nurses and Elders was suggested as an important strategy and a prerequisite in order for collaborative efforts to transpire. The Elders recommended that nurses should work more closely with them.

It was noted that none of the Elders had been asked for help or assistance by the nurses. Two of the Elders were asked for help by the nurses a long time ago. It was identified that nurses who sought assistance from the local people were more readily accepted by the Elders and members of the community. Nurses who did not request advice or information from the Elders were viewed as not being really interested in the community and as being "too proud", or "too high".

It is suggested that nurses who request assistance or information from the Elders will be perceived as possessing a positive attitude and interest towards the community. The potential benefits of this action should not be underestimated. A sincere interest and concern for Elder input may serve to enhance positive attitudes with the Elders. It may prove to be most valuable for nurses to meet with the community Elders and seek information/advice where appropriate. This is an important recommendation if nurses are relying solely upon the information received from the

CHR. It is recommended that nurses do not limit themselves to the CHR in terms of obtaining community information.

Chapter VII

FIELD INTERVIEWS WITH MEDICAL SERVICES NURSES: CONTENT ANALYSIS

7.1 INTRODUCTION

Medical Services nurses (N=10) stationed in the three Indian communities gave their consent to participate in the study. Although the sample size was small, the 10 nurses interviewed represented approximately 15% of the total target population within the province of Manitoba. Three nurses held a "Nurse-In-Charge" position, and the remaining seven nurses were field nurses. Table 7.1 gives a summary of demographic data on these health professionals.

Table 7.1

Phase I Nurses: Demographic Data*

Grew Up In Canada	Education	Time In Community
Yes 6 No 3	Hospital 6 BN/BScN 3	0-1 month 1 2-6 months 5 13-18 months 1 > 2 years 2

Transcultural Exposure	Aware of Traditional Medicine	Speak Cree	Age
Yes 4 No 5	Yes 7 No 2	No Words 3 Few Phrases 6	18-25 5 26-35 2 46-55 1 55+ 1

*One nurse did not complete the data sheet.

The majority of the nurses (66%) grew up in Canada and all were Canadian citizens. Hospital educated nurses constituted the majority (66%), while baccalaureate educated nurses were in the minority (33%). The high nurse-turnover rate became evident when the length of time the nurses had been in the community was examined: 55% of the nurses had been in their communities 2-6 months at the time of the interviews. Only two nurses were stationed in a community longer than 18 months. Almost all of the nurses (77%) were

aware of traditional Indian healing practices within their communities. The majority of the nurses were between the ages of 18-25 and approximately 77% of the nurses were under the age of 35.

7.2 UNDERSTANDING OF TRANSCULTURAL CONCEPTS

Six of the ten nurses had been exposed to transcultural nursing concepts as part of their basic nursing education. The remaining four nurses who were not exposed to this subject, had received their basic education within a hospital diploma program. The nurses possessed a fairly refined and sophisticated outlook on the subject of transcultural nursing.

> When you are nursing, you have to think these people are from a different culture and they have a different way of life. You don't automatically give them orders to go home and have a bath. These people don't have running water and they don't have a bathtub. You have to think about things like that. Their outlook on health is important. You have to think of their culture when you are treating them.
>
> Trying to understand, absorb and use their own methods and understanding of healing to put across our modern day methods rather than trying to force them on them...because this is how we do it.
>
> Everybody's culture and their expectations of medicine and anything to do with health is different everywhere you go. You always have to possess an open mind.

The difficulties involved in the application of transcultural nursing principles was identified by one nurse.

> That's not an easy thing for nurses to perform. Especially when they don't have a very good understanding of the culture or especially if they [the nurses] have biases and are not able to deal with them. There is a lot of misunderstanding in nursing.

It is worth noting that all foreign educated nurses possessed some understanding of transcultural nursing concepts. These nurses attributed their knowledge to working in communities and hospitals with a diversity of ethnic peoples.

> I trained in England. In the area I trained in, there was a large black population.

> I was trained in England and we had quite a cosmopolitan population so therefore we had to understand the Italian people, the Indian people, we had to understand the English, we had to understand the West-Indian...

Transcultural concepts and principles offered to nurses within the educational setting exposes them to basic ideas about nursing clients who may possess modes of health care different from the dominant health care system. Exposure to these concepts and principles is fundamental in fostering cultural sensitivity in terms of health care delivery practices.

7.3 ADEQUACY OF INFORMATION: INDIAN CULTURE

All of the nurses (N=10) stated that information about Indian culture offered prior to working with the Indian people was inadequate. A booklet on Indian culture, produced by Medical Services Branch (in consultation with

anthropologists) was identified by the majority of nurses as somewhat helpful.

> They [Medical Services] touched on it [Native Culture]. They have booklets on it, that try and give you some sort of insight into how the native people think. I personally don't think that it was adequate for me.
>
> They [Medical Services] emphasized good things about the job but they didn't tell us a lot about the people. They gave us a booklet on Native people.
>
> We were given, through orientation, a booklet about the Indians and that was quite good.

Several of the nurses also identified that they learned more about the Indian people once they arrived and settled into the community. This practice in the Canadian north was documented by Hodgson, (1980) and has been identified as an unacceptable method of learning about a culture (Leininger, 1976).

> Even here...I had to find out myself about the people. I'm finding out about the culture myself, day by day I'm finding out things.
>
> You learn a lot when you get out and are working with the people.
>
> Medical Services did try but I find that you learn it all when you get here. When we had main orientation though, they had two separate speakers, one in Winnipeg, and one in Thompson and they were good but, I didn't learn as much from them as I did after I got here.

It is reasonable to postulate that many nurses will find themselves transgressing cultural norms and experiencing difficulties in their communities without an adequate understanding of the Indian culture. This could possibly

lead to strained relations between the nurse and his/her community. It is also interesting to note the consensus regarding the inadequacy of the cultural orientation for the nurses. All of the nurses remarked that they would have benefited from a more indepth and detailed orientation to Indian culture. Cultural information provided to the nurses prior to their arrival and throughout their stay in the Indian communities would be of benefit to the nurses and ultimately to their Indian clients/patients.

7.4 ADEQUACY OF INFORMATION: ELDERS/TRADITIONAL HEALERS

Six of the nurses indicated that the information received about Elders/traditional healers was not adequate, while one nurse stated that the information was adequate.

> That was one thing they did talk about at the Medical Services orientation. A bit about the Elders and a respect that people have for them and about the traditional healers. They did talk about them some. They did give me a bit of an understanding about them.
>
> It was never mentioned by anyone...Medical Services or the Band. Neither party gave information.

This latter comment was rather poignant. The nurse identified that the responsibility for sharing information about Indian culture (ie. Elders/ Traditional Healers) did not rest solely upon the shoulders of Medical Services. She identified that the Indian Bands should assume part of the responsibility for orienting nurses to their communities.

Not all nurses would be receptive to this information, but it would be invaluable to those nurses who are interested in and appreciative of the alternate health care system. Ultimately, it is the patients who would benefit from nurses possessing this type of knowledge.

7.5 IDENTIFICATION OF ELDERS

The majority of the nurses (77%) acknowledged that the Elders had not been formally identified to them and most of them discovered who the Elders were through their clinical practice. That is, the Elders would identify themselves while receiving treatment from the nurses. Table 7.2 lists the key informants involved in the identification of the Elders to the nurses.

Table 7.2

Elder Informants For Phase I Nurses

1.	Nurses discovered the Elders through their work.	60%
2.	Home visits	20%
3.	Station support staff (Clerk, CHR)	20%
4.	Religious/Community gatherings	10%
5.	Band Counsellor	10%
6.	Other nurses	10%

(N=10)

All of the nurses indicated that no formal mechanism for Elder identification existed within their communities and discovery of who the Elders were occurred primarily by chance. This had serious implications in terms collaborative efforts between the nurses and the Elders. Several nurses identified that their ability to initiate referrals for patient counselling was impeded by not knowing who the Elders were, and not knowing the Elders beyond a nurse-patient relationship. The fact that the Elders were not formally identified also had serious implications in terms of the nurses knowing who some of the unofficial power brokers were in their community. While not all Elders are powerful, the literature does suggest that Elders are usually highly respected, and can be influential persons within Indian communities. The development of a professional and personal relationship with the Elders would be to the advantage of the nurses and support from the Elders could prove to be most valuable to the nurses. For example, certain public health programs may be more effective with the backing of the Elders. The need for closer communication and the formal recognition of traditional healing systems by the dominant health care system was reinforced by the data collected during Phase I.

7.6 NURSE PERCEPTIONS OF ELDER ROLE AND FUNCTION

Several nurses identified Elders as resource persons who possessed an awareness and sensitivity of the client's social situation. One nurse was particularly insightful.

> They [Elders] should be considered an asset because very often we don't have counsellors as such, or we don't have psychologists, or we don't have different people to give the patients counselling. We give the nursing treatment and they could provide the psychological support because they have the know-how. They have the understanding of the people better than we do. We are an outsider coming in, whereas they are from the inside and they know exactly how the people think and how they work.

Two other nurses echoed the same belief.

> You treat the patients medically, and you don't think of referring them to an Elder. I find that some people you come across just need an older person to talk to. This Elder would know their living situation. Many of the people have anxiety and an Elder would be the better person to talk to. No one has ever suggested this to me.

> Instead of coming to a nurse, a total stranger, they could speak to an Elder who has lived in the community, and knows how the community works and could speak to them about it. I know of a couple of patients that are having really high anxiety levels. An Elder would probably be a better person for them to talk to than, say, referring them out to the city to a physician.

The nurses identified the Elder as an individual who is aware of the social situation of the community. One Nurse-In-Charge informed the investigator that she had made arrangements for three female Elders to assist at a pre-natal workshop. The counselling and guidance role of the Elders was seen as valuable in the nurses attempts to encourage breastfeeding within the community.

> Well, for example, the ladies [Elders] that we had in for the pre-natal workshop. They told us what it was like when they were young and when they were pre-natals. They really encouraged the young pre-natals, especially the young girls to eat nutritiously because now the food was available whereas it wasn't available when they were younger. They really pushed breastfeeding as opposed to bottle feeding and acknowledged the good things about modern life as well as the good things about traditional life...a balance.

This was an excellent example of a successful collaborative effort between the nursing personnel and the Elders. The Elders were viewed as health resource persons and were invited to participate in the pre-natal workshops. The nurses were able to advocate a specific health practice (breastfeeding) through the involvement and participation of the Elders. The exact outcome of these efforts was not assessed at the time of the interview, but the NIC stated that the workshop was a success, stressing that the Elders offered valuable support.

One nurse identified diet counselling as a possible service which could be offered by the Elders.

> Oh maybe diet counselling. All the problems Indians are encountering now are because of adaptation to the western diet. With their own natural diet, they have no diabetes and very few heart problems. I think that I might send someone for counselling with a diabetic diet. I would like to make sure that the Elder understood what we were doing and why. Since I don't know any of them, it is a little difficult to see whether or not they would understand what I was aiming at.

Again, the situation where the Elders had not been identified to the nurse was a factor limiting the collaborative or interactive process. The absence of

communication and/or the existing inadequate communication between the nurses and the Elders made it difficult for either party to collaborate to any meaningful degree. The element of trust arises. Whether or not the Elder is perceived as trustworthy by the nurse-professional will certainly affect the quality of information exchanged. A lack of communication may prevent this element of trust from developing.

The nurses also perceived the following Elder functions:

1. Role Models: Several nurses identified that Elders were role models and that the Indian people could learn from their ways.

> This Elder is a role model and he is very proud of his people. He teaches them lots of things and the people respect him a lot. This Elder is an encouraging type person for his people.

2. Link With The Past: Nurses identified that the Elders possessed historical information and knowledge. The Elders were seen as valuable sources of historical and cultural information.

> The Elders that we had in for the prenatal workshop told us what it was like when they were young and when they were prenatals. What the situation was like then as opposed to what it is like now.
>
> It would help a lot if the Elders were willing to impart some of their knowledge with us. I think that would help a lot.

3. Community Problem Solving: Elders were also seen as problem solvers at the community level. The nurses

advocated that Elders should be consulted by their communities in attempts to address some of the social problems. It was the investigator's experience that Elders were actively involved in the development of solutions to many community problems. They were consulted by the Chiefs and Councils for information, guidance and direction.

> The Elders could help with problems in the community. There's a lot of counselling that needs to be done. The Elders would be of benefit to a lot of the people.

7.7 REFERRAL OF PATIENTS/CLIENTS TO ELDERS

Nine of the ten nurses stated that they had not referred patients/clients directly to an Indian Elder for counselling purposes. This statistic needs to be scrutinized in light of the fact that six out of the ten nurses identified that they would not encounter any difficulties initiating a client referral to an Indian Elder for counselling purposes. A discrepancy existed then, between perceiving no difficulties in initiating the client referrals and actually following through and implementing the referral. The absence of Elders/traditional healers within the official health care system; the communication difficulties; the absence of Medical Services policy encouraging active collaboration between field staff and the traditional health care system; the authority and influence of the NIC upon junior nursing staff; and the lack of identification of the

Elders are suggested as possible reasons for this existing situation. Most of the nurses indicated a willingness to refer patients to an Elder should a situation necessitate such a referral. The dominant health care system does not appear to formally support nor encourage nurses with collaborative and interactive efforts.

7.8 PERCEIVED DIFFICULTIES IN CLIENT REFERRALS TO ELDERS

Four of the ten nurses identified problems if they wanted to initiate a referral to an Indian Elder for client counselling. The nurses suggested the following factors contributed to collaborative difficulties:

1. The Elders were not formally identified to the nurses.
2. If the patient was a minor, then family consent would be needed.
3. Communication difficulties such as a lack of understanding of Cree on the part of the nurses, and a lack of understanding of English on the part of the Elders was identified.
4. The actual referral procedure was identified as unclear.
5. Acceptance of the Elder by the patient was identified as a possible difficulty.

None of the nurses identified any problems with Medical Services policy. In fact, Medical Services does not possess a policy which actively encourages or enhances a collaborative or interactive approach between nurses and Elders/traditional healers. It is suggested that this area of Indian health is not considered a priority by the government. The nurses indicated that the decision for such a referral would be through the Nurse-In-Charge (NIC). The NIC would possess the authority, and the decision to refer a patient would be a local concern. As one nurse stated,

> I don't think there is any policy. We would just go ahead and do it. We would go through our Nurse-In-Charge.

The control for an Elder consult then, was with the Nurse-In-Charge. The views held by the NIC had significant repercussions for the junior nursing staff in terms of collaboration and/or referrals.

7.9 PERCEIVED FACTORS HINDERING ELDER COLLABORATION

7.9.1 Attitudes

Three nurses identified that the Elder's attitude would significantly affect collaboration. The nurses stated that a positive attitude towards them was a prerequisite in order for collaboration to transpire. A sense of Elder mistrust on the part of the nurses was conveyed to the investigator. The nurses were overtly concerned with how the Elders in their communities perceived them, and the detection of a

negative attitude towards the nurses was offered as sufficient to cancel any collaborative or interactive efforts. Elders possessing a negative attitude towards the nurses were viewed as non-viable candidates for collaboration. One nurse identified that a positive attitude towards the Elders was also a prerequisite for collaborative efforts.

> You know, I think their attitude. Like if they have a negative attitude about us.
>
> I guess that would depend on the attitude of the Elders; if they are willing to work alongside the nurses and have respect for the nurses. We at the same time, must have respect for them.
>
> I think it would be their attitude and their willingness to communicate with me.

7.9.2 Communication

The second major theme identified dealt with communication. Two nurses felt that a lack of communication was a significant problem. The inability of some of the Elders to converse in English was offered as a hindrance to collaboration. The CHR was again used as an intermediary, enabling the nurses and Elders to communicate.

7.9.3 Confidentiality

One nurse suggested the issue of confidentiality as a factor. The nature of the patient's referral would have an impact on whether a referral was initiated. In essence, the

issue of confidentiality is directly related to the working relationship between the nurses and the Elders. The quality of the relationship is affected by the intensity of the communication taking place. It would be difficult and perhaps unethical for nurses to entrust the care of a patient to an Elder who is unknown to them. The necessity of intimate communication cannot be underestimated.

7.9.4 Nursing Staff Support

Of particular interest was the perspective that attitudes and practices of nurse cohorts influenced perceptions and utilization of Elders and traditional healers. The views and practices of the senior nurses were described as influencing the practices and views of the junior nurses.

> I think the people around you, the ones who you are working with. I think that the views of the other nurses might restrict you. If they didn't feel something was good, you would be hesitant to do that particular thing. I've only been here a month and they have been here longer and if they think something is not a good idea, then I'm not going to do that.

This perspective offered significant implications for the collaborative process between nurses and Elders/traditional healers. As previously identified, a referral to an Elder was a local decision, with the NIC usually being consulted and possessing the decision making authority. Should the NIC not acknowledge the possible counselling services offered by the Elders, then it is likely that the more

junior nursing staff would respect that view and not initiate a referral. The attitude and values of the NIC towards the traditional healing system may have significant influence upon the more junior nursing staff.

7.10 PERCEIVED FACTORS ENHANCING ELDER COLLABORATION

Two major strategies were identified by the nurses, which would enhance their decision to collaborate with the Indian Elders. The factors were:

1. Identification of the Elders.
2. Communication with the Elders.

7.10.1 Nurse Proposals For Improvement

Several of the nurses stated that a formal introduction to the Elders, as part of their community orientation would be of assistance.

> If the Elders are identified, if there's a time set up...there's a specific time that you could refer the people to, probably there is an office, a place, a home, a church or something.

If a formal or structured system was intact (ie. time, place, awareness of participating Elders) which incorporated the Elders as part of that system, then the Elder consultations would assume a more legitimate or acceptable role from the point of view of the nurses. The community

orientation should include an introduction to the Elders and the traditional healers.

> Knowing the Elders would also help. Especially when new nurses come here. We should have some kind of meeting to meet all the people, including Elders in the community.

7.10.2 Communication With Elders

Ongoing and more intimate communication between the nurses and the Elders was also described as a major strategy which would enhance Elder collaboration. Knowing the Elder beyond a superficial level or beyond the nurse-patient relationship would contribute to the development of trust and collaboration between the two subject groups.

> If we have some communication with them, some prior communication, we know them, we identify them and we are able to feel that this particular Elder would be able to serve a particular patient.

> Probably getting to know them a bit better. How they feel about different ideas and things that are going on in the community.

Some of the Elders would possess a more refined and developed sense of counselling than others. Consequently, it would be imperative for the nurse(s) to become familiar with the Elders in order to initiate appropriate client referrals. Identification of, and communication with the Elders are not unrealistic goals and could be attained with relative ease.

7.11 IDENTIFICATION OF TRADITIONAL HEALERS

Six nurses identified that traditional healers had not been formally identified to them, and seven nurses were aware of traditional healing practices within their communities. Of the four nurses who stated that the local healers had been identified to them, the informants were as follows:

Self-disclosure by healer	2
Local people	2
CHR	1
Request by patient to consult a traditional healer in the community.	1

Several nurses mentioned that they felt traditional Indian medicine was a secret thing and that knowledge of who the healers were in the community was privileged information.

> Apparently the traditional healers are discreet in their treatment and protective of their work.

> When I first got here, I heard that there were two medicine people here and I asked our CHR who are they, and what they do, and she just shut right up. She really didn't tell me. And one of the other nurses said... Shh... don't even ask because it's really a secretive thing and then, after that, people would talk about them and I just sort of found out who they were.

> I was here a good two years before I found this out [who the traditional healers were]. You know, it took time. As if they were waiting to trust you.

Although the nurses perceived or believed that even knowledge of the traditional healers was privileged information, the investigator was informed outright by six of the Elders that they were traditional healers (medicine men and women). In fact, several of the traditional healers shared their cures with the author and one traditional healer identified a medicinal brew she was preparing on her wood stove.

There appears to be a stereotyped view held by the nurses, and indeed by many individuals, that Indian healers wish to remain unknown or anonymous to the dominant health care system. This study suggests just the opposite. Nurses who were appreciative and acknowledged the traditional health care system became informed as to who the primary healers were within the alternate system. It would also appear that much information regarding the traditional healing system was entrusted to these particular nurses. The end result of this information exchange can be a successful blending or melding of the two systems, with cross referrals being initiated between the nurses and the traditional healers. This secretiveness about who the healers are in the community may serve to keep the health care practitioner at a safe distance from the alternative health care system. This action may be employed by the CHR or the station staff as a control mechanism for evaluating the sincerity of the nurse. It is suggested that many of the nurses have reinforced this secretiveness.

One nurse, who shared a sincere interest and respect for the traditional health system, was invited to a healer's residence and was allowed to view the healer's medicines.

> One healer used to come to the clinic and he just said to me, "Oh, its a change", he said, "me coming to you". I thought, that's an odd remark. I said, "What do you mean?" He said, "Well you come round to my place one day!", and I did. With his collection of drugs and potions and roots and everything, I knew that he was the medicine man.

Another example is illustrated below. The traditional healers taught the nurses how to mix up a salve for diaper rash.

> There is some type of wood that they let dry out and then grind it into a powder. They use to put that on babies who had diaper rash. That was brought to the nursing station by the three little old ladies [Elders] who came in for the pre-natal workshop. They told the nurses how to mix it up and everything.

The understanding that traditional healers currently wish to remain underground appears to be challenged in light of the interview data collected in this study, and the active sharing and exchanges of information between certain the nurses and traditional healers. The two groups of subjects for this study (nurses and Elders/traditional healers) have offered congruent and consistent data supporting the willingness of the healers within the alternate system to reveal and share their identities with the healers in the dominant system. The traditional healers appear willing to collaborate with the dominant health care system. It would be of great value to interview those traditional healers in

communities which are less active in traditional medicine and substantiate whether those healers share the same sentiments as their cohorts in the communities active in traditional medicine.

7.12 CONCLUSION

The nurse subjects in this phase of the study were youthful (77% under the age of 35) and most had been residing in their communities for 2-6 months. Those nurses not exposed to transcultural nursing concepts as part of their basic nursing education were of the hospital/diploma program. The cultural orientation provided to the nurses was identified as inadequate and many of the nurses learned more about Indian people after they had arrived into their communities. Cultural information received about Elders/traditional healers was also noted as being less than satisfactory. This situation is most unacceptable in that it probably contributes to cultural transgressions on the part of the nursing staff. A thorough, comprehensive and ongoing cultural orientation is needed in order for nurses to provide client-centred health care and to feel comfortable and self-assured in working with people from another culture.

The lack of communication between nurses and Elders/traditional healers was identified by both of the research groups and this theme surfaced repeatedly in the

data. Both groups (nurses and Elders) were concerned about the attitudes held by each other. The attitude of the Elders towards the nurses was identified as enhancing or detracting from client referrals. Nurses were unwilling to collaborate with those Elders who were perceived as possessing negative attitude towards them. The Elders also voiced that some nurses possessed attitudes which were not conducive towards interaction with members of the community. Nurses who did not request assistance from the community Elders (ie. social/cultural information, involvement in health care activities, advice regarding community problems, teaching, etc.) were not viewed positively. The Elders stated that none of the nurses had requested their assistance or advice with any problems. This is a significant finding given that the Elders suggested they could provide the nurses with relevant community information. The involvement of Elders within the health care system was identified as essential to the provision of quality client/patient care. This finding also has implications for the CHR position. The CHR position was established in order to enhance communication and understanding between non-Indian health care providers and the Indian community. In light of the Elders' requests for consultation from the nurses, sole reliance upon the CHR as an intermediary in terms of health care programs may limit the effectiveness of these programs. Support and input from the Elders is suggested as an important strategy for successful health program implementation.

The social role and function of the Elders was recognized by some of the nurses. The potential Elder services and/or interventions identified, suggested that the Elders were perceived by community members as important resource persons. The Elders also identified similar and congruent roles which included:

1. counsellors;
2. providers of Indian medicine, domestic advice, historical/cultural information;
3. role models for the Indian youth and,
4. community problem solvers.

Although the Elders were positively perceived, none of the nurses had initiated client referrals to them for counselling purposes, even though the majority of nurses indicated a willingness to initiate referrals. A discrepancy existed between a willingness to initiate client referrals and the actual implementation of the referral process. It was suggested that the absence of Medical Services policy, inadequate communication between the nurses and Elders, and a lack of understanding of the social and cultural role of Indian Elders have contributed to this situation.

None of the nurses identified Medical Services' policies which actively encouraged and enhanced a collaborative or interactive approach with Elders/traditional healers. As

previously noted, it appears that the fostering of an interactive or collaborative relationship between health care providers within MSB is not considered a priority.

The need for a more detailed and informative cultural orientation was identified by the nurses. They felt their cultural knowledge base was limited. Several of the nurses also identified that they learned more about the Indian people once they arrived and had settled in their communities. This is a practice which creates much hardship for the nurses in terms of community interaction and may contribute towards cultural transgressions.

The major factors hindering Elder collaboration from the nurses' perspective were:

1. Attitudes of the Elders towards the nurses,
2. communication barriers,
3. confidentiality of patient/client disorders and,
4. lack of support from senior nursing colleagues and management personnel.

The nurses suggested that the identification of the Elders and increased communication would enhance possible Elder collaborative efforts.

Several nurses felt that traditional Indian medicine and any information associated with it was secretive knowledge. It was noted that nurses who were appreciative of the

traditional healing systems and acknowledged its effectiveness became informed as to the identities of the primary healers within the alternate system. It also appeared that additional significant information about the non-formal system was entrusted to these particular nurses. The secretiveness about who the healers are in the community may serve to keep the health care practitioner at a safe distance from the alternate health care system. This action may be employed by the Indian communities as a control mechanism for evaluating the sincerity of the nurse.

That traditional healers currently wish to remain underground appeared to be challenged in Phase I of this study. The Elders/traditional healers and nurses offered congruent and consistent data supporting the willingness of the healers to collaborate with members of the dominant health care system. It is most unfortunate that collaborative/interactive efforts with the traditional health care system is limited to individual initiative on the part of the nurses. This type of interaction would be greatly enhanced if officially endorsed by MSB.

Chapter VIII

PHASE II FINDINGS: SURVEY MAIL QUESTIONNAIRE ADMINISTERED TO MEDICAL SERVICES NURSES

The entire population of Medical Services nurses and Band employed nurses who possessed autonomy in the active treatment of Indian clients within the province of Manitoba (N=64) was surveyed. A close-ended, precoded survey mail questionnaire was distributed February 14, 1986 to this population. Within 18 days, 66% (N=43) of the subjects had returned their questionnaires. A letter which thanked the nurse subjects for participating in the study, and which also requested the return of any outstanding surveys was mailed out March 4, 1986 (See Appendix L). Data collection for this phase of the research process was terminated on March 14, 1986 with an 81.2% (N=52) return rate. This return rate strengthened the credibility of the findings.

8.1 CHARACTERISTICS OF THE POPULATION

The majority of the nurses who responded (88.4%, N=46) were employed by Medical Services Branch, while 11.5% (N=6) were employees of the local Indian Bands. The average age of the respondents was 34.7 years of age with a median value of 32. Twenty-nine nurses (59.2%) were 35 years of age or younger, while 20 nurses (40.8%) were over the age of 35. Ages

ranged from 22 to 65 years. These demographic statistics identified this group as a youthful population and were congruent with the findings of Phase I.

Females comprised 92.3% of the population (N=48), while the remaining nurses were male (7.7%, N=4). The number of nurses who were male was higher in this population than in the general nursing population. For example Muff (1982) identified that men comprised only 2-4% of the total nursing population.

Most of the respondents (78.8%, N=41) grew up in Canada and 94.2% (N=49) were Canadian citizens. This finding does not support the suggestion that the majority of nurses working with Indian clients in Manitoba are not Canadian. Canadians are meeting the demand for nursing personnel on Indian reserves and health centres in Manitoba. A Canadian nursing education was identified by 84.6% (N=44) of the population, while 15.4% (N=8) of the nurses did not receive their basic nursing education in Canada. The nature of this nursing education was as follows: Hospital/diploma 53.8% (N=28), BN/BScN 44.2% (N=23), and Master's 1.9% (N=1).

The nurse turnover rate became evident when the length of time the nurse had resided in his/her community was examined. On average, the nurses in this study had resided in their communities for 20.1 months. More significantly, and indicative of the elevated nurse turnover rate, was the

median value of 9.0 months. The majority (58.8%) of the nurses had resided in their communities for 1-12 months. The range for this statistic was from 1 to 108 months.

In terms of conversing in the local Indian language, 17.6% (N=9) of the nurses reported that they did not speak a word, 70.6% (N=36) spoke a few words and phrases, 2.0% (N=1) were capable of moderate conversation, and 9.8% (N=5) were fluent in the local language. Although not officially identified in the study, it is probable that the nurses who were fluent in the Indian language were of Indian descent.

8.2 TRANSCULTURAL NURSING BACKGROUND

The transcultural nursing background of the research subjects was briefly explored. Asked whether they had been exposed to transcultural/crosscultural principles and concepts as part of their nursing education, 73.1% (N=38) stated "yes", while more than 1/4 of the nurses (26.9%, N=14) indicated that they had not been exposed to concepts of transcultural nursing as part of their basic nursing education. The educational background of those nurses without exposure to transcultural concepts was examined and almost all (78.5% N=11) were of the diploma stream. This may be a significant finding given that more than half of the nursing population in this study 53.8% (N=28) were hospital/diploma educated. The situation in which 26.9% of the health care providers were practicing in a culture

substantially different from their own without the basic concepts of transcultural nursing is unacceptable. It is unrealistic and unfair to expect nurses (or any other health care professional) to be culturally sensitive without a basic transcultural or crosscultural foundation.

The employment of transcultural nursing concepts during client/patient interaction was noted. Thirty-five percent (N=20) of the nurses stated that they used transcultural concepts "sometimes", while 57.7% (N=30) stated that these concepts were used "often". Transcultural concepts were "almost never" employed by a small percentage of the nurses (3.8% or N=2). It is imperative for health workers to provide culturally relevant and specific care to clients <u>at all times</u>. More than 1/3 of the nurses applied transcultural concepts occasionally and it is suggested that the application of these concepts and principles on an occasional basis is not an acceptable practice.

Asked whether past transcultural nursing experiences (that is, the provision of client centered nursing care to people of a different culture), influenced collaborative decisions with Indian Elders/traditional healers, 64.7% (N=33) agreed, while 15.4% (N=8) disagreed. The nurses perceived transcultural nursing experiences as playing a role in current or potential collaborative efforts with Indian Elders/traditional healers.

For most of the nurses this current employment experience was not their first contact with Indian communities. Almost two thirds of the nurses (63.5%, N=33) had worked in other Indian/Inuit communities. The nurse turnover rate takes on a new perspective given this information. An elevated job turnover rate existed, but nurses with previous northern experience were changing locations within the system. More than 1/3 (34.6%, N=18) of the nurses were inexperienced with Indian/Inuit communities.

Several nurses (23.0%, N=11) identified previous transcultural nursing experiences. They had worked with other cultures prior to being employed by Medical Services or the Indian Bands. Two nurses identified transcultural experiences in working with white society.

8.3 TRADITIONAL AND NON-TRADITIONAL HEALTH CARE SYSTEM INTERACTION

The data collected and presented in this section of the study directly and indirectly examined the degree of contact between the health care providers in the formal (non-traditional) and informal (traditional) health care systems. Data were gathered from the nursing personnel and reflected their perceptions and interactions with the indigenous health care system.

8.3.0.1 Referral Of Patients/Clients to Elders/Traditional Healers

Perhaps somewhat surprisingly, nurses appeared to be active in the referral of clients to Elders for counselling purposes. Of the nurses surveyed, 51.9% (N=27) reported that they had initiated client referrals to Indian Elders. Of the clients referred, 59.3% (N=16) were identified as experiencing positive outcomes: the client/patient received relief from his/her problem as a result of the referral. Negative results in which the client did not receive relief for his problem(s) were identified with 11.1% (N=3) of the referrals. Nurses were unaware of the results in 29.6% (N=8) of the client referrals initiated.

The majority of nurses (67.3%, N=35) were aware of traditional healing practices in their communities. Twenty-five percent N=13, reported that traditional healing practices did not occur in their communities. The percentage of nurses who actively referred patients/clients to traditional healers was substantially lower than the Elder referrals, but occurred none the less. For example, 38.5% (N=20) of the nurses had initiated referrals, while 61.5% (N=32) had not initiated any client referrals to traditional healers. Patients asked 40.4% (N=21) of the nurses for a referral to a traditional healer in another community.

The inclusion of Elders in community health programs was identified by 42.3% (N=22) of the nurses, while traditional healers were included in 19.2% (N=10) of these programs. Elders and traditional healers were incorporated into public health programs and 42.3% of the nurses stated they had actively sought advice from the Elders. Consult Table 8.1 (page 118) for a synopsis of interaction between nurses and Elders/traditional healers.

Table 8.1

Synopsis Of Nurse-Elder/Healer Interaction*

	Yes	No
1. Nurse initiated client referral to Elders.	52% (27)	48% (25)
2. Nurse initiated client referral to trad healer.	39% (20)	61% (32)
3. Aware of trad healing in the community?	67% (35)	25% (13)
4. Patient requests for trad healer?	40% (21)	
5. Inclusion of Elders in health programs?	42% (22)	58% (30)
6. Inclusion of healers in health programs?	19% (10)	81% (42)

* percentages have been rounded off

In terms of traditional and non-traditional health system interaction, nurses acknowledged that Elders were being formally identified to them by informants within the Indian communities (CHR and station support staff in particular). Almost half of the nurses (46.2%) were informed of the traditional healer identities in their communities. Nurses

were active in the referral of clients to Elders (51.9%) and healers (38.5%) and patients were also active in their requests for consultation with traditional healers.

Characteristics of those nurses initiating client referrals to Elders/healers was further explored. The relationship between the nurse's educational background and the referral process is presented in the following table.

Table 8.2

Nurses' Educational Background And Referral Activities*

	Elder Referral	Healer Referral
Diploma N=28	Yes 53% (15) No 46% (13)	Yes 46% (13) No 53% (15)
BScN/BN N=23	Yes 47% (11) No 52% (12)	Yes 30% (7) No 69% (16)

*Percentages have been rounded off

Surprisingly, the diploma educated nurses who were deficient in exposure to transcultural nursing concepts, appeared to be relatively more active than their University educated colleagues in terms of client referrals to Elders/healers. Further analysis of the data substantiated that the nurse's length of time spent in their community affected collaborative/interactive activities with the

Elders/healers. For example, the average length of stay for diploma nurses was 27.0 months (mean=12.5 months) while BScN/BN educated nurses were living in their communities on average for 12.4 months (mean=7.0 months). The diploma educated nurses had on the average, spent more time in their communities. It would appear that the length of time a nurse resides in his/her community may affect referral activities to Elders/healers.

Formal identification of the Elders and the extent to which nurses sought advice from Elders were analyzed in relation to the length of time the nurses had been in the community. (See Appendix N for data). Most of the Elders had been formally identified to the nurses within the first six months of their arrival. The majority of the nurses also sought advice from the Elders during the first six months of their stay. A most interesting finding has been identified with the plotting of this data. It was identified that most interaction between nurses and members of the traditional health care system occurred within the fist nine months of the nurses' arrival into the community, with a peak interaction at six months. It is suggested that both the nurses and the Indian communities required this time frame (six months) to accept and trust each other in order for interactive and collaborative efforts to transpire. This peak interaction time (six months) is seen as an appropriate time for MSB to offer support to the field

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staff in terms of collaborative/interactvie interactions with the Indian health care system.

The sixth month of residency in the community appeared to be a critical time point in terms of interaction with the Indian community. The highest value for the previously mentioned variables (referral of clients to Elders/traditional healers, the identification of Elders and nurses seeking advice from the Elders) occurred with nurses who had been in their communities for six months. For example:

	At Six Months	Range
1. Referral to Clients to Elders	4	0-4
2. Referral of Clients to Healers	2	0-2
3. Identification of the Elders	4	0-4
4. Nurses Sought Advice From Elders	3	0-3

It is suggested that the nurses would require at least six months within the Indian communities to become familiar and comfortable with their environment (professional and personal) It is also suggested that the Indian communities would have assessed the nurses by this time and determined their sincerity. As previously noted, this peak interaction period would be an excellent time for MSB to offer support and guidance to field staff in terms of collaborative/interactive efforts with members of the traditional health care system.

Additional analysis of the data supported the identification of four client/patient referral pattern types. The following table outlines the referral patterns.

Table 8.3

Referral Patterns to Elders/Healers by Nurses*

	Elder Referral	Healer Referral	% Nurses
Pattern I	Yes	Yes	37 (16)
Pattern II	No	No	40 (21)
Pattern III	Yes	No	21 (11)
Pattern IV	No	Yes	7 (4)

* percentages have been rounded off
N=52

The most common referral pattern was Pattern II, where client referrals were not initiated to either Elders or healers. The majority of the nurses (40%) were not active in client/patient referrals. The next referral pattern (I) identified that 37% of the nurses surveyed were active in referrals to both Elders/traditional healers. Another substantial percentage of the nurse population (21%) were active in client referrals to Elders but not to traditional healers. It is suggested these nurses were not comfortable (ie. lack of identification of the traditional healer, lack of support for the traditional healing system) in referring clients to traditional healers. Pattern IV is most interesting in that nurses did not refer clients to Elders but did initiate referrals to healers. It should be noted that only 7% (N=4) of the nurse population was found to be active with this type of referral pattern.

The next table outlines the four referral patterns in relation to the nurses' educational background.

Table 8.4

Referral Patterns and Educational Background of the Nurses*

	Elder	Healer	Diploma	BScN/BN	Average Age
Pattern I	Yes	Yes	21% (11)	7% (4)	33
Pattern II	No	No	18% (10)	21% (11)	36
Pattern III	Yes	No	7% (4)	13% (7)	35
Pattern IV	No	Yes	3% (2)	3% (2)	32

*One nurse was Masters prepared

It is evident from this table that diploma educated nurses were more active (Pattern I; Yes-Yes) in client referrals than their university educated colleagues. The BScN/BN nurses were more likely not to refer clients to Elders/healers (Pattern II; No-No), and were more likely to refer clients to Elders rather than healers (Pattern III, Yes-No). Older nurses also appeared less likely to refer clients to Elders/healers. (The average nurses' age for Pattern II referrals (No-No) was 36 years). Younger nurses (32 years) were more likely to refer clients to healers rather than Elders (Pattern IV, No-Yes).

Crosstablulation analysis of specific variables (ie. exposure to transcultural nursing concepts and the referral

of clients to Elders and healers) using Fisher's exact test (2 tail) was employed, and one set of variables was found to be significant at =.05. (See Appendix O for a listing of the variables and the "p" values). The relationship between identification of healers and the utilization of these healers by the nurses in community health programs was found to be significant (p=.0033). Analysis of the remaining variables did not demonstrate significance at =.05.

8.3.0.2 Identification Of Elders/Traditional Healers

The majority of the nurses (76.5%, N=39) acknowledged that the Elders in their communities had been formally identified to them. In comparison, 46.2% (N=24) of the nurses were informed as to who the traditional healers were in their communities. This information was disseminated to the nurses by various members of the Indian community. The informants were as follows:

Table 8.5

Identification of Elders/Traditional Healers: Informants For Phase II Nurses

	ELDERS	TRAD HEALERS
1. CHR	71.2% (37)	40.4% (21)
2. Nurse discovered on own	44.2% (23)	17.3% (9)
3. Support staff	36.5% (19)	21.2% (11)
4. Nursing colleague	30.8% (16)	17.3% (9)
5. Patient/ Client	25.0% (13)	15.4% (8)
6. Council member	25.0% (13)	15.4% (8)
7. Chief	19.2% (10)	9.6% (5)
8. Teacher	3.8% (2)	0%
9. Principal	1.9% (1)	0%

The Community Health Representative (CHR) was the most active informant, identifying the majority of the Elders and traditional healers to the nursing staff. The CHR position was originally established to serve as a liaison between the Indian community and the staff of the nursing station. This liaison function was evident in terms of providing the nurses with the identities of the community Elders and traditional healers. The second level of informant was the

nurses themselves. Whatever their motives, the nurses obtained the identities of the indigenous health care providers and shared this information with fellow colleagues. These findings were complementary to those of Phase I. It is worth noting that fellow nursing colleagues provided a substantial amount of information vis-a-vis Elder/healer identification. The support staff (clerk, cook, caretaker, housekeeper) were also an important source for Elder/healer identities.

8.4 NURSE PERCEPTIONS OF ELDERS

Overall, the perceptions of Indian Elders by the nursing personnel was positive. The Elders were perceived as a local resource and as complementing the dominant health care system. For example, 92.3% (N=48) of the nurses stated that they would be willing to collaborate with Indian Elders in the counselling of clients/patients (See Table 8.6, page 127).

Table 8.6

Nurse Perceptions of Elders

	YES	NO	DON'T KNOW
1. Client referral to Elder if supported by supervisor?	96.2% N=50	- -	3.8% N=2
2. Would initiate client referral to Elders if disapproved by supervisor?	51.9% N=27	25.0% N=13	10.0% N=5
3. Would client referral to an Elder affect licensure?	5.8% N=3	78.9% N=41	11.5% N=6
4. Would Elder collaboration enhance the present health care system?	73.1% N=38	- -	26.9% N=14
5. Are Elders respected by their own people?	88.2% N=45	2.0% N=1	9.8% N=3
6. Are Elders respected by the youth in the community?	49.0% N=24	16.3% N=8	34.7% N=17
7. Do Elders possess an understanding of psycho-social dynamics?	38.5% N=20	7.7% N=4	28.8% N=15
8. Social status of Elders is more positive than social status of the elders in non-Indian communities?	58.0% N=29	12.0% N=6	10.0% N=5
9. Other resource people in the community collaborate with Elders?	38.5% N=20	7.7% N=4	51.9% N=27
10. Do the nurses feel that the Elders trust them?	54.9% N=28	3.8% N=2	41.2% N=21
11. Financial reimbursement to Elders?	18.0% N=9	38.0% N=19	12.0% N=6

The overwhelming majority of nurses (96.2%, N=50) stated they would initiate client referrals if this action received support from their supervisors. It is interesting to note that 51.9% of the nurses would initiate a client referral to an Indian Elder, even if this practice received disapproval from their supervisor. The independent nature of these nursing professionals becomes apparent. Elder collaboration was seen as enhancing the present health care system and was not viewed as a threat to professional licensure.

A difference existed in the nurse perceptions of respect for the Elders by community members versus respect for the Elders by the youth in the community. The nurses felt that Elders were respected in their communities (88.2%, N=45 in agreement) while this respect was perceived as not as strong on the part of the Indian youth. The Elders in Phase I were asked this same question about the Indian youth. Seven Elders emphatically stated that "yes", the young people do respect their Elders. Two Elders said "some", while one Elder identified that the youth do not have respect for the Elders. The Elders perceived the Indian youth as more respectful than the nursing personnel.

The social status of Elders was viewed by the nurses as being more positive than the non-Indian elderly (58.0% in agreement, N=29). This finding suggested that a general respect for Indian Elders existed and this phenomenon was identified by the nurses. More than half of the nurses

(54.9% or N=28), felt that the Elders trusted them. More significantly, 41.2% (N=21) did not know whether the Elders trusted them or not. A substantial percentage of the nursing population did not know whether they were trusted by the Elders, and this could contribute to attitudinal problems and feelings of suspicion. Communication between the nurses and the Elders would assist to alleviate this situation.

A number of nurses (38.5%, N=20) were aware of collaborative efforts between other community resource people and the Elders. Elders then, were utilized by various local resource agencies. That 51.9% (N=27) of the nurses were not aware of local employment of Elders is also significant. An awareness of Elder utilization within the community could possibly enhance Elder collaboration within the dominant health care system. This finding may also reflect the lack of communication or awareness between the nurses and community resource persons.

Financial reimbursement for the Elders was not supported by 38.0% (N=19) of the nurse population, and 12% (N=6) of the nurses indicated a neutral stance on this particular issue. The nurses appeared unwilling to have Elders financially compensated for their potential counselling sessions. It is suggested that either the nurses felt cash payment for the Elders' services was not a culturally acceptable practice, or they felt that the services were not

worth economic reimbursement. This latter suggestion may have serious repercussions in terms of how Elders are perceived by the nursing population. That is, Elders viewed as paraprofessionals would warrant financial compensation for their interventions.

In summary, a positive perspective of the Indian Elders was identified by the nursing personnel and collaboration with Elders was viewed as enhancing the present health care system. From a professional perspective, the referral of clients to Elders was not seen as threatening to licensure by 78.9% (N=41) of the nurses. Most of the nurses felt that financial compensation for the Elders was inappropriate.

8.5 CONDITIONS PERCEIVED AS CONDUCIVE TO ELDER COLLABORATION

Thirteen conditions which patients/clients could develop were presented to the nurses. Identification of these conditions was based on Phase I research and the investigator's nursing experience. The nurses indicated (strongly agree to strongly disagree) which conditions could be addressed by an Indian Elder. "Strongly agree" and "agree" were recoded as "yes", while all other intervals were assigned a zero value. Totals for each condition were then calculated, resulting in the following table.

Table 8.7

Conditions Identified By Nurses
As Appropriate For Client Referrals
To Elders

1.	Lack of self worth	90.4% (47)
2.	Family discipline problems	90.4% (47)
3.	Social interaction problems	86.5% (45)
4.	Child neglect	86.5% (45)
5.	Parent-child conflict	82.7% (43)
6.	Child Abuse	78.8% (41)
7.	Mental health problems	76.9% (40)
8.	Minor depression	75.0% (39)
9.	Drug Abuse	75.0% (39)
10.	Traditional diet	73.1% (38)
11.	Marital discord	71.2% (37)
12.	Anxiety	67.3% (35)
13.	Wife abuse	65.4% (34)

Clients who may have a lack of self-worth or who are experiencing family discipline problems were identified as the most appropriate situations which would warrant Elder intervention. The least recommended situation was wife-abuse.

8.6 FACTORS INFLUENCING ELDER COLLABORATION

Factors presented to the research subjects in this section were identified and developed based on information gathered from Phase I field interviews. Confidentiality was noted as a factor in the initiation of a client referral by 78.8% (N=41) of the nurses. Communication barriers (that is, a lack of understanding of the local Native language) was not perceived as a factor by 52.0% (N=26) of the nursing population, while 36.0% (N=18) saw communication barriers as a definite factor which limited client referrals.

Observing a colleague refer a client to a member of the non-formal health care system was not identified as a strong influence in the referral process. More nurses (44.9%, N=22) saw this factor as not influencing them, compared to those nurses who did (36.7%, N=18). When asked whether the nurses' knowledge base regarding the social status and functioning of Indian Elders influenced their decisions to collaborate, 90.2% (N=46) of the nurses stated that this factor was important. The need for nurses to clearly understand the social role and function of the Elders was established.

The following factors were analyzed as ordinal data and were examined from two perspectives. First, the significant tail-end ranks (1-2-3 most influence; 8-9-10 least influence) were determined and second, the median value for each variable was noted.

Table 8.8

Factors Influencing Elder Collaboration: Tail End Ranks

Most Influential Factors	
1. Cross cultural experiences	48.0% (N=24)
2. Knowledge base of who/what Elders are	48.0% (N=24)
3. Attitude of Elders	24.0% (N=12)
Least Influential Factors	
8. Job orientation program	28.0% (N=14)
9. Influence of significant others	40.0% (N=20)
10. Medical Services policy	44.0% (N=22)

8.7 FACTORS INFLUENCING ELDER COLLABORATION: MEDIANS

Examination of the median values provided the most reliable analysis for each of the identified variables. The medians were as follows:

Most Influential Factors Ranked According to Mean Values

1.	Cross Cultural Experiences	3.0
2.	Knowledge of Elders	3.0
3.	Attitude of Elders	4.0
4.	Influence of Own Culture	5.0
5.	Attitude of Community	5.0

Least Influential Factors

6.	Personality Type	6.0
7.	Professional/Personal Goals	7.0
8.	Influence of Significant Others	8.0
9.	Job Orientation Program	8.0
10.	Medical Services Policy	8.0

Cross cultural experiences and knowledge of the role and function of the Elders were the most influential factors affecting Elder collaboration. The attitudes of both the community and the Elders towards the nurses were identified as influencing the nurses' decisions vis-a-vis Elder collaboration. A perceived negative attitude from either of these groups would impede collaborative efforts on the part of the nurses. The socialization of the nurse was also identified as having an influence upon decisions to collaborate with members of the alternate health care system.

The least influential factors were related to Medical Services (policy and job orientation program); personality

(type and personal goals) and the independent nature of the nurses (lack of influence of significant others). These factors are discussed in detail in Chapter IX.

8.8 CULTURAL ORIENTATION

The orientation to Indian culture was identified as satisfactory by only 27.5% (N=14) of the nurse population, while 66.7% (N=34) indicated a less than satisfactory cultural orientation. Orientation to Indian Elders and traditional healers was also identified as being less than satisfactory (78.4%, N=40). That more orientation was needed, and that nurses would benefit from a more indepth cultural orientation was indicated by the majority of the nurses (88.5%, N=46). The limited nature of the orientation was also established when 90.4% (N=38) of the nurses indicated that they learned more about Indian culture after arriving into their community, rather than in the formal orientation sessions. The need for the Chief and Council to provide additional information about their communities was identified by 71.2% (N=37) of the nurses, while 17.3% were undecided about this suggestion.

8.9 NURSE PERCEPTIONS OF TRADITIONAL HEALERS

Although the intention of this study was not to focus on nurse perceptions of traditional healers, information was gathered which may be of significance. The need to be aware of the identities of the traditional healers was identified by 82.7% (N=43) of the nurses as important. A small number of nurses (3.8%, N=2) felt that they should not be informed as to the identities of the healers. This knowledge was perceived as secretive by 60.8% (N=31) of the nurses, while (21.6%, N=11) perceived that this knowledge was readily shared with them. Almost 60% of the nurses felt that the identities of the medicine men/women were not readily shared with them. The length of time a nurse remained in a community was perceived by 86.5% (N=45) of the nurses as a significant factor in terms of the quality of community information shared with them. The word "secretive" was utilized in the questionnaire and in retrospect was perhaps not the best choice. Confidential or respectful are probably more accurate in describing this type of information.

Half of the nurses (50.0%, N=26) did not know whether their supervisors would support a collaborative health care effort with a traditional healer. Slightly less than 1/2 of the nurses (46.2%, N=24) identified that their supervisors would support the utilization of a traditional healer. When asked if collaboration with a traditional healer would

affect professional licensure, 69.2% (N=36) of the nurses disagreed. They indicated that referring a client to a traditional healer would not pose a risk to their licensure. There were three nurses (5.9%) in agreement that a collaborative effort posed a risk to licensure. Of note was the 15.7% (N=8) of nurses who did not know whether a client referral posed a professional risk.

A majority of the nurses 78.8% (N=41) felt that collaborative efforts with traditional healers enhanced the quality of client care in the present health care system. A small percentage (7.7%, N=4) felt that collaboration would not enhance the health care system at all. As with the perceptions of the Indian Elders, the nurses identified that collaborative efforts with traditional healers enhanced the current health care system.

8.10 SUMMARY

A relatively youthful Phase II nurse population was identified (median age value: 32 years). The majority of the respondents grew up in Canada and almost all were Canadian citizens. The median value for length of stay in an Indian community was 9.0 months.

Most of the nurses (63.5% N=33) had worked with other Indian/Inuit communities. The cultural orientation provided by Medical Services Branch was identified as less than

satisfactory by 66.7% (N=34) of the nurses. Orientation to the social role and function of Elders and healers was indicated as less than satisfactory by 78.4% (N=40) of the nurses and most of the nurses (88.5%) suggested that a more substantial and thorough cultural orientation was needed. In fact, 90.4% of the nurses learned more about Indian culture after arriving into their communities, than in their formal orientation sessions. Many of the nurses (71.2%) felt that the Chief and Council should provide more cultural information.

More than 1/4 of the nurses had not been exposed to transcultural nursing concepts as part of their basic nursing education. Most of these nurses were of the hospital/diploma stream. This is a significant finding given that 53.8% (N=28) of the nursing population were hospital/diploma educated. The use of transcultural concepts in practice was not consistent. Some of the nurses employed these concepts in practice occasionally (35% N=20), while others (57.7% N=30) employed transcultural nursing concepts often.

More than 1/2 (51.9% N=27) of the nurses appeared to be active in the referral of clients to Elders for counselling purposes. Of interest was the situation where diploma educated nurses were more active than their baccalaureate educated colleagues in terms of Elder/healer referrals. Nurses (42.3% N=22) identified that Elders were included in

their community health programs. The majority of nurses (67%) were aware of traditional healing practices within their communities and 38.5% reported that they had initiated client referrals to traditional healers. It was also reported that traditional healers were incorporated in community health programs by 19.3% (N=10) of the nurses.

Most of the nurses (76.5%) acknowledged that the Elders had been formally identified to them. In contrast, 46.2% were informed of the traditional healers' identities. The CHR was the most active informant, identifying the majority of the Elders and traditional healers to the nursing staff. Other informants included: nurse discovering the identities on their own, station/health centre support staff, nursing colleagues, patients/clients, Council members, and the Chiefs.

Overall, the perceptions of Indian Elders and traditional healers was positive. Both Elders/traditional healers were viewed as complementing the dominant health care system. The vast majority of the nurses (92.3% N=48) stated that they would be willing to collaborate with Elders, especially if this practice was supported by their supervisors. The nurses also viewed the Elders as being respected by their community members. Many nurses (41.2%) did not know whether the Elders trusted them or not. This lack of awareness may greatly contribute towards the perception of negative attitudes on the part of the nurses and create a climate of suspicion or mistrust.

Client/patient conditions perceived as conducive to Elder counselling included: lack of self worth (90.4% of nurses in agreement), family discipline problems (90.4%), and social interaction problems (86.5%). Conditions perceived as least appropriate were: marital discord, anxiety, and wife abuse. The three most influential factors influencing Elder collaboration were: past cross cultural experiences, knowledge of who and what Elders are, and the attitude of the Elders/communities towards the nurses. The three least influential factors were: influence of significant others, Medical Services job orientation program and Medical Services policy. These factors are discussed in Chapter IX.

It was identified that diploma educated nurses were more active in client referrals than their University educated colleagues. It was discovered that the diploma educated nurses had been in their communities, on average, for a greater length of time. The BScN/BN nurses were more likely not to refer clients to Elders/healers, and were more more likely to refer clients to Elders rather than healers. Older nurses appeared less likely to refer clients to Elders/healers. Younger nurses were more likely to refer clients to healers rather than Elders. It was also identified that most interaction between nurses and members of the traditional health care system occurred within the first nine months of the nurses' arrival into the community. A peak interaction between nurses and Elders/traditional healers occurred at six months.

Chapter IX

DISCUSSION, CONCLUSIONS AND INTERPRETATION OF RESULTS

9.1 SUMMARY

9.1.1 Statement Of The Problem

A cultural and linguistic revival was identified as taking place on Indian reserves in Canada (Adams, 1984), and included in this revival was the renaissance of traditional healing practices (Government of Canada, 1983). Holistic nursing care incorporates and supports the client's cultural beliefs and values and transcultural nursing espouses the provision of culture-specific care. Nurses who are providing primary health care to Indian clients in Manitoba and elsewhere in Canada, need to be aware of and understand traditional Indian beliefs and practices if a holistic nursing approach is to be sustained. This knowledge and awareness would enable nurses to work effectively with Indian clients and offer services which may be lacking or ineffective in the dominant health care system.

This study focused on factors affecting collaborative efforts (actual and potential) between nursing staff and Indian Elders. The utilization of Elders as health resource persons was explored, as well as the extent of contact

between nurses and traditional healers. Nurses who work with Indian clients could contribute significantly towards quality of care by referring clients to traditional healers or Elders, when warranted. This practice would enhance a holistic nursing approach and assist Native clients in preserving and developing their own health values.

9.1.2 Conceptual Framework

The research process attempted to identify perceived factors which influenced nurses' decision making processes vis-a-vis Elder collaboration. The integration of three theoretical perspectives assisted in the identification of these factors. Alland (1970), employed a system's perspective of cultural development. This perspective was utilized to identify the system interface involved in the collaborative process: the nursing profession, the Indian people, the dominant health care system (Medical Services), and the indigenous health system (traditional healers and Elders). The application of Douglas's (1982) two dimensional group-grid model of cultural controls upon consciousness, as well as a theory of interpersonal perception (E. Jones and J. Thibaut, 1958) facilitated the identification of factor clusters which influenced the collaborative process with Indian Elders. External and internal factors related to the collaborative process with Indian Elders were identified based on these factor clusters.

9.1.3 Literature Review

The review of the literature identified that the health demands of Canada's Indian population were not being met by Western medicine (Kennedy, 1984). It was also identified that Indians augmented the health services offered by the dominant health care system (Medical Services) with resources available to them in their local communities (Kennedy, 1984). A significant improvement was noted in the quality, continuity and availability of acute care medicine provided by Medical Services, but long-term improvement in the health status of the communities was seriously limited by the use of an urban medical model in remote facilities and the involvement of outside agencies in health services delivery (Morison, 1974). Several authors documented the need for change in the organization of care and a more substantial cultural orientation for health care personnel (Morison, 1974; O'Neil, 1981; Stymeist, 1972).

The majority of the current medical literature presented by physicians and allied health professionals lauded the utilization of traditional healers, especially in the area of counselling and psychotherapy. Rodgers (1979) suggested that health care providers work with these identified individuals in a spirit of true mutual collaboration and identified Indian Elders as primary therapists in the psychiatric sense and in the psychosomatic sense. Several nurses advocated a transcultural approach to nursing clients

(Dobson, 1983; Leininger, 1978; Skeet, 1981; Tripp-Reimer, 1983; Tripp-Reimer, Brink & Saunders, 1984) and supported the position that cultural factors were an integral part of providing total health care services to clients. Collaboration with indigenous health care workers was suggested by Flaskerud (1982) to enable health professionals and traditional healers to make cross referrals on an informed basis. It was identified that in the Canadian north, nurses acquired cultural knowledge largely through a trial and error approach (Hodgson, 1980).

In the discipline of anthropology, a Canadian study by Stymeist (1972) recommended that to improve the existing health delivery system, the recognition of the indigenous system was a priority. Literature within this discipline reinforced the traditional healer as an individual who possessed an intimate knowledge of patient's roles and role-sets within the community and a shared understanding of cultural values and social norms. As identified by Kleinman and Sung (1979), the personal and social meaning for the experiences of being ill in a particular cultural setting was ignored by the Western health care system.

Nurses, as primary health care workers are in the position to offer a culturally relevant client treatment milieu through the judicious utilization of, and collaboration with traditional healers and Elders. Given the alarming Indian health statistics and the limited mental

health services in the rural areas of the province, collaboration with Indian Elders could offer satisfactory results to both the client and the health care provider. The identification of those factors which nurses perceived as influencing their decisions in the collaborative process with Elders certainly warranted investigation.

9.1.4 Methodology

Nursing research conducted in the area of collaboration with Indian Elders and contact with traditional healers in Manitoba was non-existant. Therefore, an explorative-descriptive level of inquiry was identified as appropriate. The purpose of this study was to have nurses identify and substantiate those perceived factors which influenced them in the collaborative process with Elders. The research design consisted of two phases. In Phase I (PI) an open ended, semi-structured, face to face interview was administered to nurses (N=10) and Elders (N=13) on three Indian reserves in northern Manitoba. Phase II consisted of the implementation of a close ended, structured survey mail questionnaire administered to the nursing population (N=64) working autonomously with Indian clients in Manitoba.

9.2 DISCUSSION

The design of this research study facilitated the collection of rich and varied data. Implementation of a single data collection method would have placed limitations on the nature and extent of the data gathered. The face to face interviews (Phase I) produced significant data, which were analyzed for their own value and which also contributed to the development of a close ended survey questionnaire. Thus, the questionnaire was intrinsically linked to the field data. Phase II enabled detailed data to be collected on on a larger scale and enabled the findings from Phase I to be substantiated by the nursing population (N=52, 81.2% return rate).

9.2.1 Transcultural Nursing Concepts

Of the nurses interviewed in Phase I (PI), 60% (N=6) were exposed to transcultural nursing concepts as part of their basic nursing education. The nurses in PI not exposed to transcultural concepts were of the diploma stream. Findings were similar in PII with 26.9% (N=14) of the nurses not exposed to transcultural nursing concepts. The educational background of these nurses was examined and almost all 78.5% (N=11) were of the diploma stream. The diploma/hospital program appeared to be deficient in developing transcultural nursing concepts. This was a significant finding given that more than half of the nursing population in this study 53.8%

(N=28) were hospital/diploma educated. Surprisingly, the diploma educated nurses were relatively more active in terms of client referrals to Elders/healers. Further analysis of the data demonstrated that the diploma educated nurses were, on average, living in their communities longer than their BN/BScN colleagues. This factor was suggested a playing a significant role in the interactive/collaborative process with Elders/healers. The cultural orientation for the nurses should include a component on transcultural nursing concepts and principles as well as cultural content.

9.2.2 Cultural Orientation For Nurses

All of the nurses in PI (100%, N=10) stated that information obtained about Indian culture prior to working with Indian people was inadequate. This situation was also substantiated with the PII population. PII subjects (66.7%, N=34) indicated that their orientation to Indian culture was less than satisfactory, as was the orientation to Indian Elders and traditional healers (78.4%, N=40). Almost all of the nurses (88.5%, N=46) acknowledged that a more indepth cultural orientation was needed. Understanding the social role and function of the Elders was identified by the nurses as essential to collaborative/interactive efforts. The nurses were concerned with the fact that their awareness of Indian culture was limited. They overwhelmingly (90.4%, N=47) learned more about Indian culture after they arrived

in their communities. One nurse in PI identified that neither Medical Services, nor the Chief and Council offered sufficient cultural information. A substantial percentage of nurses (71.2%, N=37) supported the proposal of having the Chiefs and Councils offer more information about their communities.

This information deficit may contribute to the transgressions of cultural norms on the part of the nursing personnel. Indepth cultural information provided to the nurses prior to their arrival, upon arrival, and throughout their stay would be of benefit to both the nurses and ultimately the Indian people. Involvement of the Chiefs and Councils in the nurses' orientation to the community and Indian culture could be of great value.

9.3 ELDER/HEALER IDENTIFICATION AND HEALTH SYSTEMS INTERACTION

The majority of nurses in PI (70%, N=7) indicated that formal identification of Indian Elders had not occurred. Nurses in PII (76.5%, N=39) stated that Elders in their communities had been formally identified. Based on the analysis of population data, Elders were formally identified to the nursing staff.

The key Elder informant was the CHR who identified the Elders to 71.2% (N=37) of the nurses. The second level of Elder identification with 44.2% (N=23) was the nurses

themselves. They discovered who the Elders were on their own. The third level of informant was the station support staff (clerk, cook, caretaker) who identified Elders to 36.5% (N=19) of the nurses. Fellow nurses were also active in establishing the identity of the Elders to 30.8% (N=16) of their cohorts. The three key informants (CHR, nurse on own, support staff) were all found within the confines of the nursing station. Informants from within the community (that is, separate from the nursing station or health centre) were also active. These informants included: patients/clients, council members and the Chiefs.

Both PI and PII nurses identified a secretiveness associated with traditional healers/Indian medicine. This was not the experience of the investigator in this study as many of the Elders readily shared their identities as healers and provided information related to traditional cures. They were most generous in sharing information which could be considered secretive. PII findings substantiated that traditional healers were formally identified to 46.2% (N=24) of the nursing personnel and 38.5% (N=20) of the nurses had initiated client referrals to healers. Traditional healers were also included in 19.2% (N=10) of the community health programs. These findings indicated a willingness on the part of many nurses and traditional healers to cooperate and collaborate in client treatment regimes and client/community education. It is proposed that

the secretiveness associated with the non-formal health care system was not substantive, but merely a ritualized and expected response on the part of nurses and perhaps the support staff. For example, although 60.8% (N=31) of PII nurses indicated that the knowledge of traditional healers was secretive, 67.3% (N=35) of the nurses were aware of traditional healing within their communities, 38.5% had referred clients to traditional healers and 46.2% had the healers formally identified to them. Based on these findings, nurses were in active contact with traditional healers. The sharing of this information with the nursing staff may be a calculated action on the part of the informants, based on the receptiveness and acceptance of the nurse practitioner towards the alternate health system. This phenomenon may serve to protect cultural information from outsiders until a trusting relationship can be established.

It was identified that at six months, nurses were most active in terms of Elder/healer interaction and client referrals. It was suggested that this six month time frame enabled the nurses and the community to establish the nature and quality of their professional-personal relationships. It was also suggested that MSB utilize this peak period of interaction to foster collaborative/interactive efforts between field staff and the traditional Indian health care system.

The elevated nurse turnover rate needs to be examined in relation to nurse-Elder/healer contact. The median value for the nurses' length of stay in an Indian community was 9.0 months. That interaction between nurses and Elders/traditional healers occurred given the limited time nurses had been in their communities was significant. Most of the nurses had resided in their communities for a relatively short time span and yet almost half (46.2% N=24) had been informed as to the identity of the traditional healers.

Data from Phase I (field interviews) identified that nurses who displayed a genuine interest in the traditional health care system were recipients of information considered secretive. A native American nurse (Primeaux, 1977) proposed that the nurse's attitude of acceptance can influence the utilization of medicine-men and Leininger (1967) stated that nurses who possessed a receptive attitude would gain valuable insights about indigenous health care systems. The findings in this study were in concurrence with these authors. The aura of secretiveness associated with Indian medicine/traditional healers appeared to be more the case of reverance, respect and acceptance on the part of the practitioner in the dominant health care system.

The interviews conducted in PI also provided case studies demonstrating interactive efforts with the indigenous healers. Two significant findings related to these cases were:

1. The identification that Indian people were utilizing both health care systems in their quest for symptom relief and,
2. Indian people were sharing their experiences of the traditional system with their nurses.

In PII, 40.4% (N=21) of the nurses had received requests from patients for referrals to traditional healers outside of their communities. Both health care systems were utilized by the Indian people. Kennedy (1984) stated that the health demands of Canada's Indian population were not being met by the Western medical system, and that Indians were augmenting the health services offered to them with resources available to them in the folk sector. Kennedy's observations have been supported in this study. The ramifications of this shopping behaviour on the part of Indian clients are many. Perhaps the central point for consideration is the necessity of nursing personnel and traditional healers to communicate with each other. Denial of the potency of either system may place clients in hazardous situations. As identified in Case 9 (PI research), a lack of communication between nurses and a traditional healer contributed to a health crisis for a client who was treated concurrently by the nurses and a traditional healer. A collaborative effort between the various practitioners (traditional and non-traditional) may have avoided this situation.

The Elders in PI (six of whom were identified as traditional healers) stated that it was an appropriate and acceptable practice to let the nurses know who the medicine men/women were in the community. Cross referrals were suggested as one reason for informing the nurses as to the identities of the traditional healers. The Elders also identified that their people had faith in, and were actively utilizing the traditional healing system. Augmentation of the Western health care system was also identified by the Elders.

9.4 NURSE PERCEPTIONS OF ELDERS AND POTENTIAL ELDER SERVICES

Nurses in PI identified Elders as resource persons who possessed an awareness of the client's social situation. This cultural awareness and sensitivity was suggested as an important and valuable asset in terms of counselling clients. The anthropological literature extensively acknowledged this situation (Foster, 1978; Jilek, 1971; Kleinman & Sung 1979). Elders in PI stated that they could provide services such as counselling, Indian medicine, domestic advice, and historical information. The young people of the community were identified as likely candidates for these counselling services.

Nurses in PII also perceived the Elders in a positive light. The Elders were perceived as a local resource who

complemented the dominant health care system. In fact, 73.1% (N=38) of the nurses indicated that collaboration with Elders would enhance the present health care system, and would not pose a threat to professional licensure. In lieu of the positive perceptions, actual interactive and/or collaborative efforts needed to be scrutinized. Nine out of the ten nurses interviewed in PI stated that they had not referred clients/patients directly to an Indian Elder for counselling purposes. Of the nurses surveyed in PII, only 51.9% (N=27) reported that they had initiated client referrals to Indian Elders. (This statistic is viewed as significant, given the nurses short length of stay in Indian communities). Although almost all of the nurses supported collaborative efforts with the Elders, just over 1/2 of the nurses actually engaged in this type of behaviour. It was suggested that the nurses were on their own in terms of supporting the non-formal health care system. Encouragement and support from superiors would enhance and augment interactive/collaborative activities.

Potential client conditions perceived as appropriate for Elder referral were identified by the PII nurses. With a population agreement of greater than 80%, the following conditions were identified as appropriate for referral:

1. Lack of self worth
2. Family discipline problems

3. Social interaction problems
4. Child neglect
5. Parent-child conflict

Given the inadequate mental health services available in the rural areas of the province, the utilization of Elders as local health resource persons is an appropriate and logical proposition. The fact that 59.3% (N=16) of the clients referred to Elders experienced positive results with their problems was most encouraging and lends support to this recommendation.

9.5 FACTORS INFLUENCING ELDER COLLABORATION

Phase I nurses identified that a lack of formal identification and a lack of communication affected their abilities to initiate a client referral to an Indian Elder. The Elder's attitude towards the nurses was also identified as significantly affecting the collaborative process. A positive attitude towards the Elders was also deemed a prerequisite for client referrals to occur.

Phase II nurses (78.8%, N=41) identified that confidentiality was a concern in the referral process with Indian Elders. The following factors were also identified as important:

1. Cross cultural experiences
2. Knowledge of Elders

3. Attitude of Elders towards nurses
4. Influence of own culture
5. Attitude of community towards nurses

9.5.1 Cross Cultural Experiences

Past transcultural nursing experiences were identified by 64.7% (N=33) of the nurses as influencing collaborative efforts. Almost 2/3's of the nurses 63.5% (N=33) had worked with other Indian/Inuit communities and approximately 23.0% (N=11) identified previous non-Indian crosscultural experiences. The tangible past experiences of nursing in a foreign culture were identified by the nursing population as the most significant factor which influenced collaborative efforts.

9.5.2 Knowledge Of The Elders

Knowledge of the social status and functions of the Indian Elders was noted by the nurses as an important factor influencing the collaborative process. It would be most difficult to engage the services of Elders without an understanding of their social/cultural roles and functions. The present knowledge of Elders may be less than satisfactory given that 78.4% (N=40) of the PII nurses indicated an inadequate orientation to their role and function. More cultural information was identified as needed, and a more indepth cultural orientation was

advocated by 88.5% (N=46) of PII nurses. This finding has significant implications for the Medical Services cultural orientation program and indeed, has implications for nurses who care for Indian clients within the urban setting.

9.5.3 Influence of Culture

The influence of the nurse's culture was substantiated as a factor in the collaborative process with Indian Elders. Socialization of the nurse (formal and informal) exerted an influence upon perceptions of Indians and Indian Elders. Whether the nurse had been positively or negatively exposed to Natives would influence their interactions on all levels.

9.5.4 Attitude Of Elders/Community Towards Nurses

The attitude of community members towards the nursing personnel surfaced in both phases of this study and was perceived as significant in the referral process. Almost half of PII nurses (41.2%, N=21) were not aware of whether the Elders trusted them. The Elders in PI also identified concerns with the attitude of some of the nurses. Both groups then, were perturbed with attitudes. Positive attitudes between the nurses and Elders would be fostered through ongoing communication. Communication is fundamental to the development of trust between the two groups and without a more intimate interaction, nurses and Elders will continue to maintain suspicious and/or negative attitudes

toward each other. Open dialogue is a prerequisite to the collaborative/interactive process.

9.5.5 Least Influential Factors

Five factors were substantiated by PII nurses as having minimal influence upon the collaborative process with Elders. The factors identified were:

1. Personality type
2. Professional/personal goals
3. Influence of significant others
4. Job orientation program
5. Medical Services policy

The lack of influence with several of these factors can be attributed to the independent personalities of the nursing personnel. Nurses working on Indian reservations and health centres are required to possess independent decision making skills. It is suggested that these nurses were autonomous individuals. The influence of significant others needs to be closely examined. The influence of the nurse-in-charge and other nursing colleagues was identified by nurses in PI as affecting the client-Elder collaborative process. PII nurses indicated that supervisor support affected the client referral process (51.9% (N=27) and that nursing colleagues were active in the identification of Elders and traditional healers. It is interesting to note

that in spite of the findings, the nurses did not feel that this factor was significant in the collaborative process with Elders/healers.

Medical Services policy was identified as the least influential factor. This variable would probably have been viewed as more significant if Medical Services possessed a clear policy on collaborative efforts between nurses and members of the traditional health care system.

9.6 CONCLUSION

It is acknowledged that the general health status of Canada's Indian people has improved greatly over the last several decades. There are however, serious limitations and concerns associated with the provision of current health care services by the Medical Services Branch of the Department of Health and Welfare Canada. Limitations specifically related to the focus of this investigation will be discussed in detail.

The Federal Government has proclaimed on a national and international level, the importance of incorporating traditional healing practices into the health care services provided to the Indian people (Canada, 1980; Government of Canada, 1983; Medical Services Branch, 1984). It would appear that the government acknowledges the relevance and utility of traditional healing approaches within

international and national political organizations, but has not actively nor formally initiated collaborative or interactive efforts between staff at the field level (physicians, nurses working in nursing stations and health centres) and members of the traditional health care system. Field nurses in this study, were unable to identify MSB policy which actively encouraged a collaborative approach with the non-formal health care system, in terms of client care.

In 1972, Stymeist suggested that in order to improve the existing health delivery system, recognition of the indigenous health system was a priority. He also recommended that, "effort should be made to approach and understand indigenous medical systems with reference to their form and structure as well as their content...this understanding, once achieved, should be part of the training for all doctors and nurses" (p. 275). Little progress has been made in over a decade since these specific recommendations for improvement in the provision of Indian health care were made.

The Government recommended that, "in the areas of the country where traditional medicine is still important, we should encourage a closer working relationship between traditional healers and physicians" (Canada, 1980, p.72). The three Indian reservations involved in this study were identified as active in traditional Indian medicine. The

health care practitioners in these communities noted that a closer working relationship with traditional healers was not actively encouraged by Medical Services Branch. The nurses did identify that MSB provided transportation services for clients who requested a referral to a traditional healer, but the client had to request the referral through the Chief. As reflected by the data in this study, it is suggested that MSB is only marginally supportive of the non-formal health care system and does not actively encourage field staff to collaborate with Elders and traditional healers in the field setting.

The Indian people identified that one of their major goals in the area of traditional medicine was the need for a closer working relationship between medicine men and physicians and an orientation of health personnel in the ways of traditional health practices (Jackson, 1980). The nurses in this study identified their orientation to Indian culture as inadequate and that information related to the social role/function of Indian Elders/healers was almost non-existant. The majority of the nurses identified the need for a more indepth cultural orientation. Almost all of the nurses learned more about Indian culture after they had arrived in their communities and it was suggested that this knowledge deficit contributed to cultural transgressions on the part of the nursing staff. Given the elevated nurse turnover rate (median value for length of stay=9.0 months),

MSB would be wise to place more emphasis on the cultural aspects of health service within the orientation process, rather than on administrative technicalities.

Orientation provided to nursing personnel should address the following areas:

1. Review of basic concepts and principles of transcultural nursing.
2. Traditional Indian health care system: Structure, function and current utilization.
3. The role and function of Elders/traditional healers within Indian communities.
4. The necessity of local human resource utilization within Indian communities.
5. The reality of social, environmental and political situations on Indian reserves in Manitoba.
6. Problems and situations beyond the influence and control of the health care provider.

The need for a MSB policy which actively encourages and supports collaborative/interactive efforts between members of the formal and non-formal health care systems has been substantiated. The case studies in Phase I (field interviews with nurses and Elders) demonstrated that Indian clients were utilizing both health care systems in their quest for symptom relief. In fact, 40% of the Phase II nurses had been asked by clients/patients for traditional

healer services. These situations overwhelmingly identified the need to support the non-formal health care system by Medical Services personnel. Denial of the traditional healing system by MSB will not undermine its presence and potency. It is suggested that denial of the traditional health care system may place clients at an increased health risk or contribute to client health crises. If the raison d'etre for MSB is to provide quality health care to the Indian people, then the development of policies which facilitate Indian clients in preserving and nurturing their own health values should be a priority and not merely an area of "respectful interest". Nurses identified that they were willing to initiate client referrals to Elders if this practice was supported by their immediate supervisors. A policy which directed supervisors and field staff towards a collaborative/interactive approach with the traditional health care system would contribute to an improvement in relations between field staff and traditional healers/Elders, and ultimately improve the quality of health care provided to the Indian people.

This study demonstrated that nurses who displayed an interest and appreciation for the traditional healing system were entrusted with abundant information related to the non-formal health care system. The majority of the nurses however, felt that traditional Indian medicine and any information associated with the traditional healing system

was secret information. It was identified that this secretiveness was not a substantive or permanent phenomenon. The formal identification of healers to 46.2% of the nurses, active client referrals to traditional healers by 38.5% of the nurses, and the involvement of traditional healers in public health programs challenged the permanency of this secretiveness. The fact that 67.3% of the nursing population were aware of traditional healing practices in their communities demonstrated that information related to the non-formal health care system was being disseminated to the nursing personnel. This information was shared with nurses whose length of stay was 9.0 (median value) months. It was suggested that the aura of secretiveness served to protect cultural information from unappreciative persons. Once a trusting relationship was established, an exchange of information about the traditional health care system followed suit.

That traditional healers currently wish to remain underground was also challenged in this study. Both the nurses and Elders/traditional healers offered congruent and consistent data supporting the willingness of healers to reveal their identities. The traditional healers appeared to be most willing to initiate collaborative and interactive efforts with members of the dominant health care system.

A relatively youthful nursing population was identified (median age value was 32 years). The majority of the

respondents grew up in Canada and almost all were Canadian citizens. Nurses, on their own initiative, appeared to be relatively active in the referral of clients to Elders for counselling purposes. The referral of clients to traditional healers was also reported by 38.5% of the Phase II nursing subjects. These statistics must be considered significant given that nurses were initiating these referrals on their own accord without apparent support from their employer.

Most of the nurses (76.5%) acknowledged that the Elders had been formally identified to them. In contrast, only 46.2% of the nurses were informed of the traditional healers' identities. The CHR (community health representative) was the most active informant, identifying the majority of the Elders and traditional healers to the nursing staff. The CHR's role of culture broker was substantiated. Other informants included: nurse discovering identities on own, station/health centre support staff, nursing colleagues, patients/clients, council members and the Chiefs.

Elders stated that nurses who did not rely on the local people for assistance of any kind, were viewed by the community as being "too proud" or "too high" to request advice or assistance. None of the Elders in the study indicated they had been asked for help or assistance by the nurses. Many nurses (41.2%) did not know whether the Elders

trusted them or not. This lack of awareness may contribute towards the development of negative attitudes on the part of the nurses and create a climate of suspicion and mistrust. It was suggested that nurses who request assistance or information from the Elders will be perceived as possessing a positive attitude and interest towards the community. Community health programs which are based on local input (ie. Elders) would probably be embraced with much more support than programs developed in isolation from influential community members. A sincere interest and concern for Elder participation may serve to enhance positive attitudes between the nurse and the community. It would be most valuable for nurses to meet with their community Elders and seek information and/or advice. Reliance solely upon the CHR for community information may be a tactical error on the part of the nurses in terms of building a positive relationship with the Indian community at large.

The Elders identified the following social roles and functions.

1. Counsellors/Advisors
2. Guardians of Historical Information/Perspectives
3. Providers of Indian Medicine

These roles were carried out to varying degrees by the Elders interviewed during Phase I. It was interesting to

note that the Phase II nurses also identified the counselling role for the Elders and viewed them as sources of historical information.

The Elders supported the idea of informing the nurses as to the identities of the community healers. The concept of cross referrals was suggested by the Elders as one reason for informing the nurses about the healers. They readily supported this concept and stated that patients/clients who did not receive relief from their symptoms with White man medicine, would benefit from consultation with the traditional healers. The Elders also noted that Indian people have faith in and are actively utilizing the traditional healing system.

The combination of Indian and White man medicine was not supported by the majority of the Elders. The possible consequences of combining the two medicines ranged from inactivation of the Indian medicine to death of the patient. Two healers stated that a mixture of the two medicines was allowed, as long as the White medicine was not overly potent. They maintained however, that caution was needed as well as thorough consultation with the local healers.

Elders were generally perceived positively by the nursing population and were identified as being respected by their own people The Elders were seen as a local resource and as potentially complementing the dominant health care system.

The nurses (92.3%) indicated a willingness to collaborate with Indian Elders in the counselling of clients/patients. Unfortunately only 51.9% of the nurses actually engaged in collaborative/interactive efforts with the Elders. The frequency of these collaborative/interactive efforts with the Elders was not established in this study. Support from supervisors would transfer this willingness into action. It was suggested that nurse support for the Elders was needed in terms of the Elders' paraprofessional status within the Indian communities.

Traditional healers were also viewed positively and collaborative efforts with healers were seen as enhancing the quality of client care in the present health care system by 78.8% of the nurses. A smaller number of nurses (38.5%) had initiated referrals to traditional healers. Both Elders and healers then were involved in community health programs. For example, 42.3% of the nurses involved Elders in their community health programs, while 19.2% (N=10) of the nurses involved traditional healers in their programs.

Factors influencing the collaborative process were identified. The most influential factors were: past transcultural experiences, Knowledge of who/what Indian Elders are, influence of the nurse's culture and attitude of the Elders and community towards the nurses. The least influential factors were: personality type of the nurse, professional/personal goals, influence of significant

others, job orientation program and Medical Services policy. Client/patient conditions identified as appropriate for Elder referral included: lack of self-worth, family discipline problems, social interaction problems, child neglect, parent-child conflict and minor depression.

Over 1/4 of the nurses (26.9%) had not been exposed to transcultural nursing concepts as part of their basic nursing education. Of this number, 78.4% (N=11) were of the hospital/diploma stream. This was a significant finding given that the majority of the nursing population in the study (53.8% N=28) were hospital/diploma educated. Surprisingly, further analysis identified that diploma educated nurses were relatively more active in their referrals of patients/clients to Elders/traditional healers. Baccalaureate educated nurses were noticeably more hesitant in initiating referrals to both Elders and healers. Additional data analysis demonstrated that the diploma educated nurses had been living in their communities for a longer period of time than their university educated cohorts. Diploma nurses were in their communities (on average) for 27.0 months as compared to baccalaureate nurses with an average stay of 12.4 months.

Crosstabulation analysis of several variables affecting the referral process was conducted, utilizing Fisher's exact test (2X2, df=1). The identification of healers to the nurses and the utilization of these healers in community

health programs was significant (p=.0033) at =.05. The remaining variables were not found to be significant.

9.7 LIMITATIONS OF THE STUDY

The basic design of this study warrants that each phase be assessed for limitations.

9.7.1 Phase I: Field Interviews With Nurses/Elders

Although the quality of the data collected in this phase was rich and informative, the limited Elder sample (N=13) was a constraint. The pool of potential Elder subjects was large, thus limiting the generalizability of the findings related to the Elder interviews. The sample for nurses (N=10) was appropriate (15% of the total population).

The methodology for the selection of the Elders must also be examined. The Chiefs and Councils identified the Elders in their communities. Although this non-random sampling method was viewed as a reasonable and prudent procedure, inherent biases in the Elder identification process may have been present.

Translator services were required for the majority of the Elder interviews and consequently, the transfer of information across two languages may have been impeded or limited. In addition, content analysis was performed solely by the investigator. Concurrent analysis by others may have

contributed to the identification of additional content categories or further substantiated the existing categories.

9.7.2 Phase II: Survey Mail Questionnaire to Medical Services Nurses

The reliability and validity of the survey questionnaire was not established statistically. Phase I nurses indicated a limited understanding of the term "Elder". Based on this finding, the investigator provided terms of reference for the Phase II population (See Appendix K). It was not certain whether Phase II nurses clearly understood the concept of Elder.

The exclusion of the nurses who participated in Phase I research (N=10) may have eliminated valuable data. The nurses on these reserves were active in Elder/traditional healer interaction. It is suggested that the statistics reflecting interaction between the two research groups would have been augmented had these particular nurses been included in the population sample. In retrospect, the Zone Nursing Officers may have also offered significant data related to Elder collaboration and healer interaction.

9.8 IMPLICATIONS OF THE STUDY

9.8.1 Implications For Nursing Practice

The findings of this study have significant implications for nurses (both in rural and urban settings) who provide care for Indian clients. Perhaps the most significant implication is the need for nurses to employ the use of transcultural nursing concepts in the care of clients. The provision of culture specific care in not an issue in academic settings requiring debate and discussion, but is a necessity within the realm of nursing practice. The provision of culture specific care is a prerequisite for holistic nursing. The acknowledgment and support of the Indian client's own traditional health care system where appropriate, could significantly contribute to an improvement in his/her health status. Collaborative efforts with members of the traditional health care system would enhance the quality of care that Indian clients are currently receiving. Collaboration is based on the appreciation and recognition of the effectiveness and efficaciousness of the alternate health care system on the part of the nurse professional.

Many Indian people are utilizing both health care systems in their quest for symptom relief. The literature (Jackson, 1980; Kennedy, 1984) and the findings of this study have substantiated this phenomenon. Nurses need to be aware of, and sensitive to this practice. Moreover, nurses need to be

supportive of this practice. This fact establishes the need for nurses to recognize the role of traditional health systems in client treatment regimes. Nurses need to support the Elders in order to provide credibility and paraprofessional status to these community members. Informed cross referrals to Elders/traditional healers would decrease the potential health risks to clients. Communication between nurses and Elders/healers within the Indian communities is a practice which warrants immediate implementation.

An unwillingness to incorporate or involve the traditional health care system has been documented as potentially detrimental to the health status of Indian clients. Nurses would be wise to request that the Elders and traditional healers who are active in their communities be formally identified. This request would demonstrate an interest and concern to the community about the traditional healing system. This action would also assist in the initiation of communication between the nurses and recognized leaders (official and unofficial) in the Indian communities.

Client conditions which were perceived by the nurses as appropriate for referral to Elders included: lack of self-worth, family discipline problems, social interaction problems, child neglect, parent-child conflict and minor depression. This recommendation for practice is appropriate

given the severely limited counselling resources and mental health services on the majority of reserves and health centres in Manitoba. The utilization of local human resources (Elders and traditional healers) would be of great assistance to both the nurses and their clients.

9.8.2 Implications For Nursing Education

Although the nurses in this study were providing care to a specific cultural group, the need for nurses to possess and practice transcultural concepts is universal. The multi-ethnic composition of Winnipeg and other centres in Manitoba substantiates this need for nurses to be exposed to crosscultural concepts as part of their basic nursing education. The findings of this study stress the importance of including transcultural concepts in the nursing curriculum. It is most unfortunate and distressing that much of the content related to transcultural concepts within nursing curriculae is limited to a token status. A more indepth and fundamental presentation of this nursing subfield is needed to promote cultural awareness and sensitivity within potential graduates.

This study also demonstrated the need for nurse educators to ensure their students are made aware that people may possess health care modes as effective (and more effective) then the dominant medical model based health care system. The utilization of local resource persons by nurses in areas

of the province where professionals are scarce needs to be stressed.

9.8.3 Implications For Theoretical Orientation

The usefulness and appropriateness of the conceptual framework will be discussed in detail. It is the investigator's intention to demonstrate how the conceptual framework aided in providing a means to data identification and collection. Areas of the conceptual framework which require further refinement will also be identified. As previously noted, three theoretical orientations were integrated to form the conceptual framework for this research.

9.8.4 Overview of the Conceptual Framework

Alland's Adaptation in Cultural Evolution (1970), was utilized to develop two areas within the thesis:

1. Analysis of the resurgeance of traditional medicine amongst Canada's Indian people.
2. Identification of the major systems involved in collaborative/interactive efforts between nurses and Elders/traditional healers.

9.8.4.1 Analysis of the Resurgeance of Traditional Medicine

The dominant western health care system aided by environmental (smallpox, tuberculosis etc.), political (establishment of the reserve system, BNA act etc.), and religious events (conversion of the Indian people to Christianity), served to abate and erode the existing traditional healing systems over time. Alland posited that "populations carrying more efficient systems replace or absorb populations carrying less efficient systems if such groups are competing for the same environment" (1970, p. 180). It was suggested that the Western healing system was initially viewed as a more efficient healing system than the traditional system. Over time, traditional healers could not compete with the apparently powerful and effective Western health care system and as a result, a massive wave of diffusion was initiated, with the flow originating from the Western health system and severely diluting the traditional healing system.

Currently, the Indian people are voicing their concerns regarding the Western health care system. They are claiming this system is not adequate in coping effectively with many of the ills of their society. It was suggested that the dominant health care system was perceived as a less effective system. It was posited that a second major wave of diffusion was taking place, a century or more following

initial cultural diffusion. This wave with its emphasis on traditional values can be viewed as an attempt to ensure Indian survival. The flow is now originating at the grass roots level and is pervading the dominant health care system: Medical Services.

Based on Alland's theoretical framework, it was suggested that recent interests in traditional Indian culture and healing are being invested in order to maximize survival and minimize destructive forces. Elders are being approached by an increasing flow of Natives seeking advice and council, healing and inspiration, interpretation of the past and present, which are prerequisites for future survival (Couture, 1979).

9.8.4.2 Identification of Systems

Alland suggested that cultures undergo evolutionary changes as a result of system interface. Four key systems involved in client referrals to Elders/traditional healers were identified. They included:

1. the nursing profession,
2. Indian communities,
3. the dominant health care system (Medical Services),
4. the indigenous health system (traditional healers and Elders).

This investigation focused primarily upon the nursing profession. Alland's theoretical perspective assisted in the development of this system interface.

9.8.4.3 Nurses and Perception

Nurses' perception of factors affecting collaborative/interactive processes with Elders/traditional healers constituted the major thrust of the research effort. Thus, the concept of perception within a system's network became the basis of the conceptual framework.

Two theoretical perspectives on perception were utilized. An interpersonal construct of perception was obtained from the discipline of psychology (Jones and Thibaut, 1958), and a social construct of perception was employed from the discipline of sociology (Douglas, 1982). Jones and Thibaut proposed that an individual interacts with three kinds of goals:

1. Facilitation of personal goals: Promotes the arousal of value-maintenance.
2. Deterministic analysis of personality: Social, physical and biological determinants cause an individual to behave as s/he now does. (Causal-genetic set).
3. Applications of social sanctions: Generalized norms which the individual considers to be applicable to

the present behaviour setting. (Situation-matching set).

Douglas (1982) suggested that the process of perception was largely cultural. She attempted to systematize cultural constraints and developed a two dimensional group-grid model which reduced social variation to only a few grand types. In essence, Douglas suggested that there were two dimensions of control over the individual:

1. Group commitment: Strength of allegiance to a group. (For example, a learned profession).
2. Every remaining form of regulation. This is the grid component. (For example, laws, policies etc.).

With regards to this study, the social environment termed, ascribed hierarchy, was deemed applicable to the nurses working for MSB. The ascribed hierarchy cell reflects the environment of large institutions where loyalty is rewarded and authority is respected. An individual knows his/her place in a world that is securely bounded and stratified. It was suggested that Medical Services nurses function within a bureaucratic institution where loyalty is rewarded and authority is respected.

The similarities between Douglas and Jones and Thibaut were identified and integrated. The system interface which was based on Alland's concepts was analyzed according to the following variables:

1. influence of culture
2. influence of personality
3. professional and personal gratification
4. maximizing beneficent social response
5. generalized (personal, social and environmental) norms/rules
6. professional and personal goal attainment

Based on these common variables, two factor clusters were formulated. External (including environment) and internal factor groups were established.

9.8.4.4 External Factors

Perception of institutional policies regarding utilization of alternative healing systems; formal and informal input from Zone Nursing Officers and allegiance to the group (what other nurses thought of transcultural nursing practices) were identified as possible external factors affecting nurse perceptions. Community and social factors were identified as a subcomponent of this factor group. These factors exerted an influence upon the process of collaboration, rather than on the concept of perception

itself. For example, the degree to which Elders are respected and valued within a community may have substantial implications in terms of process implementation.

9.8.4.5 Internal Factors

These factors were related to the influence of culture, personality, personal gratification and goal attainment on the part of the nursing professional. Past transcultural nursing experiences; socialization (formal and informal) and exposure to transcultural nursing concepts were identified as influencing the nurses' decision-making process.

9.8.5 Relationship of Findings to the Conceptual Framework

Findings from the investigation will now be examined in relation to the conceptual framework.

9.8.5.1 Traditional Medicine

Field interviews with Elders/traditional healers and nurses identified that Indian people were utilizing both the formal and non-formal health care systems. It was noted that many of the Indian people were comfortable and indeed found it necessary to seek health care in both systems. The effectiveness of Indian medicine was supported. These findings were in concurrence with Alland's suggestion that systems viewed as more effective will replace or absorb less efficient groups if competing for the same environment.

9.8.5.2 External Factors

The application of Douglas' (1982) social typology cell of ascribed hierarchy towards Medical Services nurses was challenged in light of the research findings. Both Phase I and II nurses indicated that Medical Services policy was not an influential factor in terms of collaborative efforts. The nurses stated that they would possess autonomy in making these type of decisions. The independent nature of the nurses was also supported when 51.9% stated that they would initiate client referrals to Elders/healers even if this procedure was not supported by their immediate supervisors. The nature of the nurses' work requires individuals who are independent decision makers and who possess a high degree of autonomy in their professional roles. It is suggested that many of the nurses employed by Medical Services are individualistic. The application of Douglas' ascribed hierarchy cell was found to be an inaccurate grouping of Medical Services nurses.

Allegiance to the group, that is what other nurses think about transcultural nursing practices was documented in this study. Phase I nurses identified that the more senior nursing staff had an influence over the junior staff in terms of collaborative efforts. Phase II nurses however, indicated that the influence of significant others (fellow colleagues, Zone Nursing Officers etc.), was not an influential factor in the collaborative process with

Elders/healers. The independent nature of the nursing personnel and the lack of influence of significant others challenged these aspects of Douglas' theoretical perspective. The influence of culture however, was documented in this study. Nurses indicated that the influence of their own culture was a major factor in terms of collaborative efforts with members of the non-formal health care system.

Serveral of the factors obtained from Jones and Thibaut and Douglas were not identified by the nurses as influencing their perceptions of collaborative efforts. These factors included:

1. personality type of the nurse
2. professional/personal goals
3. Medical Services policy
4. influence of significant others

The lack of influence of most of these factors is again attributed to the independent nature of the nursing personnel, and the absence of a MSB policy encouraging collaborative/interactive activities with healers/Elders.

The conceptual framework utilized did not address certain variables which influenced the perception of the nurses. These variables were identified upon completion of data analysis. It was identified that the following additional factors affected the perception of the nurses:

1. Influence of knowledge base related to the social role and function of Elders,
2. influence of attitudes and,
3. past transcultural nursing experiences.

It was identified that the nurses' knowledge base of the cultural/social role of the Elders/traditional healers influenced their perception of these individuals. Nurses who were unaware of the role of Elders perceived their potential contributions to client/patient care as minimal.

The nurses indicated that if the Elders or the community possessed a negative attitude towards them, then collaborative efforts would be compromised. The factor repeatedly surfaced with both research groups (nurses and Elders) and was identified as a major factor influencing the perceptions of the nursing staff.

Although somewhat obvious, past transcultural experiences were not identified or addressed in the conceptual framework as a factor influencing the nurses' perception. Past experiences was ranked by the nurses as one of the most influential factors affecting the perception of collaborative/interactive efforts. The tangible past experiences of nursing in a foreign culture was identified by the nurses as one of the most significant factors influencing perception of Elders/healers.

These three variables were not identified in the conceptual framework but were developed from the analysis of the research data. The investigator originally attempted to obtain a conceptual framework which offered a perfect fit in terms of the focus of this study. Integration of three separate perspectives from anthropology, sociology and psychology facilitated the development of a conceptual framework for this study. Although the framework was found to be weak in several specific areas, and failed to identify three important factors affecting perception obtained from the data analysis, it did provide guidance and direction in terms of linking the investigative ideas to the field data.

9.8.6 Implications And Recommendations For Nursing Research

The subfield of transcultural nursing has received little investigative attention. An organized and systematic approach needs to be adopted in order to effectively contribute to the present knowledge base. This organized approach should contribute to the knowledge base in an incremental manner, rather than a hit and miss fashion. Since a paucity of information existed regarding nurse-Elder collaboration and nurse-healer contact, this study was focused at an exploratory-descriptive level of inquiry. Based on the data collected in this study, the following implications and recommendations for nursing research are suggested:

1. The design of this study contributed to the richness of the data collected. This design was conducive to investigation of the subject matter. There are other areas within transcultural nursing which would benefit from the utilization of this design structure.
2. Factors influencing collaboration between nurses and Elders were established. A more sophisticated analysis can now be implemented whereby hypotheses can be formulated about these factors and measures of association related to these particular factors can be established statistically.
3. The impact of transcultural nursing concepts upon nursing practice needs to be statistically supported. Although briefly exposed in this study, an indepth investigation into the statistical relationship between presentation of these concepts and influence upon nursing practice warrants scrutiny.
4. Key Elder/healer informants were identified in this study. The role of these culture brokers (CHR and station support staff in particular) who provide information to the nursing staff needs to be explored. How these individuals decide what information is shared with whom would be an area of particular interest. A study focusing on the role of these individuals as gatekeepers of cultural information would be most valuable.

5. The sample size of PI Elders (N=13) requires augmentation in order to strengthen generalizability of the findings. A more substantial sample size (N=50-100) of Elders from reserves where traditional healing practices are not as common as the locations identified in this study, would enable generalizations to be inferred. The present role and functions of Elders on Indian reserves is suggested as an important future study.
6. There were native nurses who were surveyed in the study. This status was ascribed based on their replies which indicated a fluent command of the Indian language. Any future research about nurses on Indian reserves or health centres should consider these individuals in the research design.
7. The nature and frequency of Elder and healer referrals needs to be identified. That is, the type of referral initiated by the nurse or the condition with which clients request referrals to traditional healers needs to be identified. An awareness of those conditions frequently treated by local healers may assist in adapting the treatment regimes within the dominant health care system in order to obtain or enhance symptom relief for clients.
8. The combination of Indian and White medicine was briefly identified in this study. A more detailed anthropological approach with a substantially larger

sample size would assist in the analysis of this phenomenon. An incongruency in this concept was identified in PI, where the inability to combine any white-man medicine and Indian medicine was not unanimous among the various healers. It would be of value to ascertain whether this is a local phenomenon or whether it is occurring within the general population of Indian healers.

This exploratory-descriptive investigation produced much exciting data and has substantiated that a great amount of research is needed within this subfield of nursing. It is the investigator's intent to systematically build upon this initial research and contribute to the transcultural nursing knowledge base.

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Appendix A

INTERVIEW FOR NURSES: PHASE I

Interview Schedule

Code Number _____

1. Have the Elders in your community been identified to you? By whom? How? When?
2. Have the traditional healers (medicine men/women, shamans) been identified to you? By whom? How? When?
3. What difficulties might a nurse encounter if he/she wanted to refer a client to an Indian Elder for counselling purposes?
4. What type of services or interventions can Elders offer as health resource people in Indian communities?
5. What is your understanding of transcultural nursing? Was this subject matter taught to you in school?
6. What sort of things might prevent a nurse from collaborating with Elders?
7. What sort of things would enhance a nurse's decision to collaborate with Elders?

8. Did you find that you were given adequate information about Indian culture prior to working with Indian clients? What was satisfactory? What was unsatisfactory?
9. Did you find that you were given adequate information about traditional healers and Elders prior to working with Indian clients? What was satisfactory? What was unsatisfactory?
10. Have you ever referred a client/patient to an Indian Elder for counselling? Could you describe the events in general? Did things work out? What problems did you encounter, if any?
11. Have you ever collaborated with a traditional healer? (ie herbalist, medicine man/woman, shaman) Could you describe the events? What were the outcomes?
12. Are you aware of traditional healing practices occurring in your community? How did you discover this?

Code _____

Sex: F____ M____

Did you grow up in Canada? Yes____ No____

Are you a Canadian Citizen? Yes____ No____

Nature of nursing education: Hospital trained____

College degree_____

University: BN/BScN____ Masters____ PhD__

Length of time in present community: 0-1 month_____

2-6 months____

7-12 months____

13-18 months____

19-24 months____

>2 years_____

Have you worked in other Indian/Inuit communities?

Yes___ No___

Have you worked in other jobs that have required trans-cultural nursing practices?

Yes___ No___

Were you exposed to transcultural nursing concepts as part of your nursing education?

Yes___ No___

To the best of your knowledge, is traditional medicine practiced in your community? (ie. elders, shamans, medicine-men, sweat lodges, etc.)

Yes___ No___

Do you speak the local language?

Not a word. _____

A few words;simple phrases. _____

Moderate conversation. _____

Fluent. _____

Age:

18-25 _____

26-35 _____

36-45 _____

46-55 _____

55+ _____

Appendix B

INTERVIEW FOR ELDERS: PHASE I

Code number _____

Sex: F___ M___

Date of Birth: (If available) _____

Interview Schedule

1. Do your people come to you for help? What kind of help do they want? What kind of help do you give them?
2. Have nurses ever asked you to help with some of their patients? What happened? What did they ask you to do? Was is a good or a bad experience for you?
3. What help can Elders offer to their people? Can you give examples?
4. Do you think it is important for nurses to know who the Elders are in your community? Why would this be a good or a bad thing?
5. Why do you suppose some nurses ask Elders for help with their patients and some do not?
6. What should a nurse do if he/she wants to ask an Elder for help with a patient?

7. Do the young people respect the Elders? Why? Why not?
8. Would a combination of Indian and "white man" medicine be a good or bad thing? Why? Why not?
9. Do you think it is good to let nurses know who the medicine men/women are in your community? Why would this be a good or bad thing?

Appendix C

CONSENT FORM FOR NURSES PHASE I

You are invited to take part in a study of nurses who are working with Indian clients in Manitoba. From this study, I hope to learn more about transcultural nursing practices and the collaboration with Indian Elders for counselling purposes. You are being invited to be an unpaid participant since you are working as a nurse with Indian clients in Manitoba.

The study is being supervised by Dr. Lesley Degner, (474-9664), Associate Professor at the School of Nursing, University of Manitoba. Dr. John O'Neil from the Department of Social and Preventive Medicine and Carol Opochinsky, Assistant Professor with the School of Nursing, University of Manitoba, are also involved in the study as advisors and content experts.

If you decide to participate in this study, I would like to ask you a few brief and general questions in an interview format about your background, experiences and thoughts on Indian Elders. I would like to use a tape-recorder while you share your experiences but, if the presence of the tape-recorder makes you uncomfortable in any way, it will not be used. If the tape-recorder is used, the tape will not be identifiable with you and the tape will be erased upon transcription of the data. The general questions and interview about Indian Elders will take approximately 30 to 60 minutes of your time. The time you take to talk with me should not interfere significantly with your job and will not unduly inconvenience you.

Any information that is obtained in connection with this study that could be identified with you will remain confidential and will be disclosed only with your written permission. The written report of this study will not refer to specific individuals or to specific locations or bands, and no individual will be identifiable.

Your decision whether or not to participate in this study will not have any repercussions to you as a nursing professional. Your nursing supervisors will not be informed of who participates in the study, and who does not. If you do decide to participate in this study, you will be free to discontinue your involvement at any time during the interview. Your participation in this study will assist in

the research in an area of nursing that has not been previously explored.

If you have any questions or concerns, please ask! If you have any additional questions later you may contact the investigator, David Michael Gregory, BScN, RN, at or in writing at, School of Nursing, Bison Building, University of Manitoba, Winnipeg, R3T-2M7.

You will be given a copy of this consent form to keep. The final results of the study will be forwarded to your Zone Nursing Officers and as previously mentioned, research subject anonymity will be maintained. No individual or location will be identified by name. A brief summary of the study will also be made available upon request.

Code number _____

You are making a decision whether or not to participate. Your signature indicates that you have read the information provided above and have decided to participate in this study. You are free to withdraw at any time after signing this form should you choose to discontinue participation in this study.

_____ _____

Date Signature

_____ _____

Date Signature of Investigator

Appendix D

CONSENT FORM FOR ELDERS: PHASE I

You are invited to take part in a study of nurses who are working on Indian reserves in Manitoba. From this study, I hope to learn more about nurses who decide to work with Elders. I am not interested in Indian medicines or the ways of Indian healing. I am interested in the views of the Elders. I would like to ask you a few questions about nurses. For example, have nurses ever asked you to work with patients? I would also like to ask you about what Elders can do to help patients who need someone to talk to. You are being invited to be an unpaid participant since you have been identified by the Chief and Council as being an Elder in your community.

If you decide to participate in this study, I would like to ask a few questions about your experiences and thoughts on working with nurses and patients. I would like to use a tape-recorder to tape the translator if you cannot speak English. If the tape-recorder bothers you in any way, it will not be used. If the tape-recorder is used, no one will know it is you sharing your experiences with me. The tape will be destroyed once I get to Winnipeg and type what has been recorded on the tape. The questions and interview will take approximately 1/2 hour to 1 hour of your time.

The written report of this study will not refer to specific Elders, but will refer to Elders as a group. No individual Elder, nor community will be identified in the final report.

Your decision whether or not to participate in this study will not have any effects on the nursing care you are receiving in your community. If you decide to participate in the study, you will be free to stop at any time during the interview. Your participation will assist in the research of an area of nursing that has not been previously explored. Any information that you share which could be identified with you, will remain confidential and will be disclosed only with your written permission.

If you have any questions or concerns, please ask! If you have any additional questions later, you may contact the investigator, David Michael Gregory (nurse) at , or in writing at the School of Nursing, Bison Building, University of Manitoba, Winnipeg, Manitoba, R3T-2M7.

You will be given a copy of this consent form to keep. Results of the study will be forwarded to your Chief and Council. You may obtain a copy of the results from your Chief, or you may contact the investigator directly.

Code number _____

You are making a decision whether or not to participate. Your signature or mark indicates that you understand the information provided above and have decided to participate in this study. You are free to withdraw or stop at any time after signing this form should you choose to discontinue participation in this study.

_____ _____
Date Signature or Mark

_____ _____
Date Translator

_____ _____
Date Signature of Investigator

Appendix E

CONSENT FORM FOR ELDERS: PHASE I (CREE TRANSLATION)

ᑲᐎᐊᓂᒧᒋᑲᑌᐠ

ᓇᐢᑯᒧ ᒪᓯᓇᐃᑲᐣ ᑫᑌᔭᑎᕽ ᑲᑲᓄᒧᐍᒋᐠ : ᓂᐢᑘᐟ ᐁᐱᐢᑭᐢᑕᐢᑌᐠ

ᐁᑲᑵᒋᒪᑳᐎᔭᐣ ᑭᑕ ᐎᒋᐃᐁᔭᐣ ᑳᐎᑖᑭᐢᑫᓂᒪᑲᓂᐚᑭᐠ ᒪᐢᑭᓯᐅᐢᑫᐚᐠ ᑳᔭᑐᐢᑫᒋᐠ ᐃᐢᑯᓂᑲᓂᐠ ᐅᑕ ᒪᓂᑐᐸ᙮ ᐅᒪ ᑲᐎᑭᐢᑫᐣᑕᑳᐠ, ᐁᐸᑯᓴᓂᒧᔭᐣ ᑭᑕ ᑭᐢᑫᓂᒪᑭᐠ ᒪᐢᑭᓯᐅᐢᑫᐚᐠ ᑲᐃᑌᐣᑕᑭᐠ ᑭᑕ ᐎᑕᒧᐢᑫᒪᒋᐠ ᑫᑌᔭᑎᕽ᙮ ᒧᓇ ᐄᓇ ᐁᐄᐣᑖᑭᐢᑫᐣᑕᒪᐣ ᐃᓂᓂᐤ ᒪᐢᑭᓯ ᐊᐳ ᑲᐃᑐᑕᐠ ᐃᓂᓂᐤ ᐁᐣᑕᐎᐃᐍᐠ᙮ ᐁᐄᐣᑖᑭᐢᑫᐣᑕᒪᐣ ᐁᐃᑌᐣᑕᑭᐠ ᑫᑌᔭᑎᕽ᙮ ᐁᐄᑲᑵᒋᒥᑕᐣ ᐊᑎᐤ ᑲᑵᒋᑫᒧᐄᓇ ᐅᐅᐠ ᐅᒋ ᒪᐢᑭᓯᐅᐢᑫᐚᐠ᙮ ᑕᐱᐢᑯᐨ, ᑭᑲᑵᒋᒋᑯᐋᑫᓇ ᒪᐢᑭᓯᐅᐢᑫᐚᐠ ᑭᑕ ᐎᒋᐊᐦᑯᐠ ᐅᑕᑯᐦᐚᐠ᙮ ᐁᐃᑌᐣᑕᒪᐣ ᒥᓇ ᑭᑕ ᑲᑵᒋᒥᑕᑯᐠ ᑕᐣᓯ ᐁᐃᑌᐣᑕᑭᐠ ᑫᑌᔭᑎᕽ ᑕᑭᐃᓯ ᐎᒋᐊᒋᐠ ᐅᑕᑯᓯᐚ ᑳᑕᐍᓂᒪᒋᐠ ᐍᓂᐃ ᑭᑕ ᐎᒋᐊᔭᒥᐃᑯᒋᐠ᙮ ᑭᑲᑵᒋᒥᑲᐄᐣ ᐁᑲ ᑭᑕ ᑎᐸᐊᒪᑲᐎᔭᐣ ᐁᐃᒋᐃᐍᔭᐣ ᐊᓂᐢ ᑭᑭ ᓇᐅᓯᓂᑯᐚᐚᐤ ᑭᑐᑭᒪᑲᓂᒥᐚᐚᐟ ᒥᓇ ᑭᐚᓇᓯᐁᓂᒥᐚᐚ ᑕᐱᐢᑯᐨ ᐅᑲᑲᓄᒧᐍᐤ ᑭᑕ ᐃᑕᑭᓯᔭᐣ ᑭᑎᑕᐎᓂᐠ᙮

ᑭᐢᐱᐣ ᐃᑌᐣᑕᒪᐣ ᑭᑕ ᐎᒋᐃᐍᔭᐣ ᐅᒪ ᑲᐎᐊᓂᒧᒋᑲᑌᐠ᙮ ᐁᐃ ᑲᑵᒋᒥᑕᐣ ᐊᑎᐤ ᑲᑵᒋᑫᒧᐄᓇ ᑳᐃᓯ ᑭᐢᑫᐣᑕᒪᐣ ᒥᓇ ᐁᐃᑌᐣᑕᒪᐣ ᐁᐎᑕᒧᐢᑫᒥᐢᑭᐠ ᒪᐢᑭᓯᐃᐢᑫᐚᐠ ᒥᓇ ᐅᑕᑯᓯᐚᐠ᙮ ᐁᐎᐊᐸᒋᑕᔭᐣ ᐁᓂᒪ ᑲᐱᐣᐸᓂᐠ, ᐊᔭᒧᐎᐣ ᑳᐅᓂᑫᐸᓂᐠ ᐁᐎᐅᓇᒪᐟᐠ ᑭᑎᑌᐢᑕᒪᑫᒥᐚᐟ ᑭᐢᐱᐣ ᐁᑳ" ᑲᐢᑭᑕᓴᑯ ᑭᑕ ᐊᑲᓇᓯᒧᓴᐠ᙮ ᑭᐢᐱᐣ ᑭᑭᓄᒪᐃᑯᐚᐟ ᐅᒪ ᑲᐅᓂᑫᐸᓂᐠ ᐊᔭᒧᐃᐣ, ᒧᓇ ᑳᔭᐸᐢᑕᐣ᙮ ᑭᐢᐱᐣ ᐊᐸᐢᑕᔭᐤ, ᒧᓇ ᐍᓴᐠ ᑭᑕ ᑭᐢᑫᐣᑕᐟ ᑭᓇ ᐁᑭ ᐊᒋᒧᐢᑕᐎᔭᐣ ᑳᐃᓯ ᑭᐢᑫᐣᑕᒪᐣ᙮ ᐊᐣᑕ ᑲᑭᐅᓂᑫᐸᓂᐠ ᐊᔭᒧᐎᐣ ᑭᑕ ᓴᐚᓇᒋᑕᓂᐚᐣ ᐃᐢᐱ ᑭᑕᑯᓯᓇᐤ ᐎᓂᐯᐠ ᒥᓇ ᑭᑕ ᒪᓯᓇᐃᑲᑌᐚ ᐊᔭᒥᐃᓇ ᑲᑭ ᐅᑎᓂᑫᐸᓂᑭᐠ᙮ ᑲᑵᑫᒧᐃᓇ ᒥᓇ ᑫᔭᒥᓇᓂᐚ ᐊᐣᑕ ᐋᐱᑕᐟᐊᐢᑲᐸᓂ (½ hour) ᐃᓂᑯ ᐯᔭᐠ ᑎᐸᐃᑲᐣ ᑫᑭᐢᑕᔭᐣ᙮

ᐅᒪ ᑫᒪᐢᓯᓇᐃᑲᑌᐠ ᑳᑭᐊᓂᒧᒋᑲᑌᐠ ᒧᓇ ᑭᑕ ᑕᑯᒪᑲᓂᐚᐣ ᐍᓇ, ᒪᑲ ᑭᑕ ᑕᑯᒪᑲᓂᐚᓇᐠ ᑫᑌᔭᑎᕽ ᑲᑭ ᒪᒪᐟᐎᒋᐠ᙮ ᒧᓇ ᐱᑯ ᐯᔭᐠ ᑫᑌᔭᑎᐢ, ᓇᐣᑕᐟ ᐃᑕᐃᐣ ᑭᑕ ᒥᐢᑯᒪᑲᓂᐚᐣ ᐊᐣᑕ ᐃᐢᑳᐟᔭ ᒪᐢᓯᓇᐃᑲᓂᐠ᙮

ᑭᓇᐅ ᑭᑕᔅ ᓂᕆᑎᓕᐅᔪᓐ ᓀᐦᑕᓐ ᓯᒪᓐ ᓂᐊᐱᔅ, ᓂᕆᑎᓕᐅ x ᑭᓇᐅ ᑭᑕᔅ ᑭᔭᓂ-ᓂᕆᑎᓕᐅᔪᓐ ᓀᐦ, ᓂᑭ ᐊᔪᒥᐊᐋ ᐊᐋ ᐃᓕᑐᓂᑎᓐ ᑌᓂ ᒪᐃᐦᐢ ᓂᐱᐊᐢ (David Michael Gregory) ᒪᓇᑭᒧᐃᓇᑎᓐ ᐃᒪ ᒧᐯᐃᐊᔪᒍᐃᓐ ᐊᑭᑕᒧᐢ ᓀᐦᑕ ᐃᒪᒥᓀᐊᕐᓯᓂᐅ ᐃᑌ ᓂᑭᑭᓀᐦᐃᐊᓂᒋᐢ, ᑕᐃᒧᐢ ᓂᐊᒥᓂᑌᐃ ᐋᑎᓂᐊᐢ, ᒥᒪ ᑭᓇᑭᓀᐦᒪᑐᓂᒥᔅ ᐃᑕ ᐃᒪ ᒪᓂᑐᕽ, ᐃᓂᐯᐢ, ᒪᓂᑐᕽ, R3T-2M7 x

ᑭᓂ ᒥᓂᓂᐃᐢ ᒪᒧᓀᐃᓂᐢ ᐃᒪ ᐃᒪ ᓂᑭᐊᓂᒪᒥᓂᑌᐃ, ᓂᓂᓀᐅᑕᒪᐢ x ᑫᑎᐦᕽᓂ ᐃᒪ ᓂᑭ ᐊᓂᒪᒥᓂᑌᐃ ᑭᑕ ᐃᒧᑎᐦᔭᐊᒋᐊᐋᐢ, ᑭᑐᑭᓂᑲᓂᒥᐊᐋᐢ ᒥᐅ ᑭᐋᓀᒧᐊᓂᒥᐊᐋᐢ x ᓂᑭ ᐋᐢᕽᑌᓐᐋᐢ ᑐᐢᑕᒪᒥᒪᐊᐋᐢ ᑭᑐᑭᓂᑲᓂᒪᐋᐋ ᓀᐦᑕ ᐊᔪᒥᐊᔪᐢ ᐊᐋ ᐃᒪᓂᑐᕽ ᑫᑎᐦᐢ x

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ᐊᑭᑕᒧᐢ ᑫᐃᒧ ᑭᐦᑫᑕᒼ ᐃᒪ ᒪᒧᓀᐃᓂᐢ _____

ᒥᓀ ᐁᐋᓂᐢᑕᒪᒪ ᐃᐃᒥᐃᐁᔪᓀᐅ ᓀᐦᑕ ᐁᑫ, ᒥᐃᓂᐃ ᓀᐦᑕ ᑭᒪᑫᐦᒧᓀᐅᐃᒼ ᒥᑕ ᐃᑕᐦᑌᐢ ᐁᐢᐦᑎᓂᒪᒪᐢ ᐃᑕ ᑫᒪᒧᓀᐅᐃᒼᑌᐢ, ᐃᑕ ᒪᒧᓀᐅᐃᒼᑌᓂᐢ ᒥᑕ ᐃᒧᐃᐁᔪᓐ ᐃᒪ ᐃᑕᐦᑌᐢ ᐃᒪ ᒪᐃᐦᐢᑕᒪᒪᐢ, x ᒥᓀ ᒥᑎᐯᓂᒧᐦ ᐃᐢᐦᒥᒪᔪᓐ ᐧᐋᐃᐦᐯ ᒥᔅ ᐊᑕᐦ ᐁᑕᐦᐢᑕᒪᒪᐢ ᐃᒪ ᑫᐃᐢᐦᑎᓂᒪᒪᐢ ᐃᑕ ᐃᒪᓂᑐᕽ, x

_____ ᐁᐋᓂᐢᑕᒪᒪᐢ

_____ ᒥᐃᓂᐃ ᓀᐦᑕ ᒥᒪᑫᐦᒧᓀᐅᐃᒼ

_____ ᐁᐋᓂᐢᑕᒪᒪᐢ

_____ ᐃᓂᐃᐢ ᑫᐃᒧᐢᑕᒪᒪᐢ

_____ ᐁᐋᓂᐢᑕᒪᒪᐢ

_____ ᐃᓂᐃᐢ ᑫᐃᒧᐢᑕᒪᒪᐢ

Appendix F

LETTER TO REGIONAL NURSING OFFICER, MEDICAL SERVICES BRANCH, MANITOBA REGION

303-475 Dysart Road,
Winnipeg, Manitoba,
R3T-2M7.

July 5, 1985.

Mr. William Rutherford,
Regional Nursing Officer,
Medical Services Branch,
Winnipeg, Manitoba

Dear Bill:

Please find enclosed five copies of the thesis proposal "Factors Determining The Utilization of Indian Elders As Health Resource Persons By Nursing Personnel", which will be submitted to the Ethical Review Committee at the University of Manitoba in September. This proposal should be viewed as a draft since changes will undoubtedly be recommended following meetings with my thesis committee (August 1, 1985) and the Ethical Review Committee. I shall forward the revised and final proposal to you as soon as possible.

The proposed research entails examining an area of nursing that has received little investigative attention. The potential benefits to the nursing profession and Medical Services as a result of this research are timely, given the recent political and cultural developments of the Indian people. In brief, I had planned to conduct "face-to-face" interviews with MSB nursing staff at reserve A, B, and C. during January 1986. Approximately 10 nurses would be involved in this qualitative aspect of the investigation. As well, I am in the process of obtaining permission from the Chiefs and Councils of these reservations in order to interview approximately 10 elders. Upon completion of the qualitative phase of this proposed research, I would like to submit a closed question survey to 74 MSB nurses in the province of Manitoba. This research phase would be conducted during February-March of 1986.

I have received a small grant from the Northern Studies Trust Fund at the University of Manitoba ($2,000.00) which can be utilized for air fare and accommodation up to a maximum of $30.00/diem. Given this information, I would like to make the following requests of your department:

1) Permission to conduct research within the Manitoba Region. That is, access to interview 10 nurses for Phase I research and distribute a questionnaire to 74 nurses (Phase II of the research design).

2) Reside in Medical Services accommodations for a maximum of $30.00/diem while conducting the research. The total number of days anticipated is 15.

Should you require additional information or clarification of the proposal, please do not hesitate to contact me. Your attention regarding this matter is most sincerely appreciated.

Yours truly,

David Gregory, BScN,RN.

Appendix G

LETTERS REQUESTING PERMISSION FOR PROPOSED STUDY
TO CHIEFS AND COUNCILS

405-475 Dysart Rd.,
St. Andrew's College,
Winnipeg, Man.,
R3T-2M7.

July 11, 1985.

Dear Chief: A, B, C: [Information which would identify individuals or locations has been substituted with A,B,C.]

Greetings from Winnipeg! I am a nurse in the final year of my Master's program at the University of Manitoba. I just completed nursing for two years at God's Lake Narrows and have taken an unpaid leave of absence with Medical Services to obtain my Master's Degree in Nursing.

Part of my degree requirements includes a thesis. While working at God's, I was introduced to the Elders in the community. I began to see that these people could assist me in the care of some of my patients. That is, the Elders were an excellent health resource for the community. Therefore, I decided to propose an investigation about nurses. I am trying to find out why some nurses collaborate with Elders and why some do not. The principle focus of my thesis is nurses.

I am also interested in the Elders' views about counselling patients who are referred to them by nurses. This is why I am writing to you and your Council. It would be most valuable to this investigation, if I could interview 3-4 of Elders from your community. The total number of Elders I would consult would be ten: four from reserve A, three from reserve B, and three from reserve C. You and your Council would select the Elders who would be willing to consent to an interview. The interview would last for approximately 30 minutes. Translation services may be required for the Elder interviews. Would it be possible to request that a Band CHR translate? I am in the position to offer this individual $50.00 for their professional services.

Please be assured Chief A, B, C, that I sincerely believe that Elders possess a tremendous amount of knowledge and wisdom which can be offered not only to your People, but also to the health care team. I am in the process of obtaining permission to interview Medical Services nurses. The interviews with the nurses would take place in January 1986. This is when, with your permission, I would also like to interview those chosen Elders in your community. The Elders may offer significant information about collaboration with nurses.

Copies of the final publication would be sent to you and your Council upon completion. I have enclosed a draft of my thesis proposal. Some of the information contained in it may be of interest to you. Please note that my proposal must receive approval from the Ethical Review Committee here at the University in September. Changes could be requested in the types of questions I have composed. Located on page 51 of the draft are the questions I would like to pose to the Elders. Appendix F (page 56) is the consent form for the Elders. I am having a similar consent form translated into Cree syllabics for those Elders who read in syllabics. Any suggestions you may have with regards to interviewing the Elders would be earnestly received.

I must apologize for not meeting with you personally, but I am limited financially. Your assistance and consideration of the proposal is sincerely appreciated. Please inform me, at your convenience, as to your decision whether or not I may interview the Elders from your community. Please do not hesitate to contact me with any questions or requests for clarification of the proposal.

Respectfully,

David Gregory, RN

P.S. Chief A, B, C, if you will be in Winnipeg and could accommodate me into your schedule, I would be delighted to meet with you and discuss the proposal.

Appendix H

COVER LETTER TO BE SENT TO NURSING PERSONNEL:
PHASE I

303-475 Dysart Road,
St. Andrew's College,
Winnipeg,Manitoba,
R3T-2M7.

December 9, 1985.

Nurse-In-Charge/Community Health Nurse
Nursing Station/Health Centre,
Manitoba

Dear Nurse-In-Charge/Community Health Nurse:

I would like to take this opportunity to invite you to participate in an investigation about collaboration between nurses and Indian Elders in the counselling of patients/clients. Please find enclosed an interview schedule, a few short answer type questions, and a consent form. Could I ask you to think about sharing your experiences and views about this subject matter? I have received permission to conduct this investigation from Medical Services, and the Chief and Band Council, and will be arriving in your community to conduct possible interviews with you and a few pre-selected Elders. Should you decide to participate, I will take approximately 30 to 60 minutes of your time (at your convenience) and conduct an interview. Your input into this investigation will be sincerely appreciated.

With thanks,

David Gregory, BScN, RN.

Appendix I

COVER LETTER FOR NURSING PERSONNEL: PHASE II

303-475 Dysart Road,
St. Andrew's College,
Winnipeg, Manitoba
R3T-2M7

February 14, 1986.

Nurse-In-Charge/
Community Health Nurse
Nursing Station/Health Centre
Manitoba

Dear Nurse:

I would like to take this opportunity to invite you to participate in an investigation about the referral of patients/clients to Indian Elders for counselling purposes. Please note that all responses are confidential and anonymous and no personal information resulting from the survey will be divulged to any other third party (public or private).

I have received written permission from the Regional Director of Medical Services (Mr. Paul Cochrane) to conduct this investigation and it has been reviewed by the RNO and your ZNO. Due to the small sample size, your response will be most valuable. You have been identified as a possible respondent because you are a nurse working for Medical Services with Indian patients/clients.

Should you decide to participate, please complete the enclosed questionnaire. This should take approximately 20 minutes of your time. The questionnaire has been coded so that no one will know who the specific respondents are. Once completed, please place the questionnaire in the pre-stamped, pre-addressed envelope and forward it to me. Could I ask you to mail your responses by March 10, 1986?

At the conclusion of this investigation, I will forward an executive summary to the Zone Office and should you let me know in writing, I shall forward you a copy of the summary as well.

If you have any questions about the questionnaire, please contact your Zone Nursing Officer or call me at between 8:00 p.m. and 10:00 p.m. Monday to Thursday.

I can appreciate how busy you are. Please accept my sincere thanks and gratitude for your contribution towards an area of nursing research which has been most neglected.

Sincerely,

David Gregory, RN, BScN.

Appendix J

CONSENT FORM FOR NURSES: PHASE II

You are invited to take part in an investigation about nurses who work with Indian clients in Manitoba. From this investigation, I hope to learn more about transcultural nursing practices and the collaboration with Indian Elders for counselling purposes. You are being invited to be an unpaid participant since you are working as a nurse with Indian clients in Manitoba.

This research is being supervised by Dr. Lesley Degner, (474-9664), Associate Professor at the School of Nursing, University of Manitoba. Dr. John O'Neil from the Department of Social and Preventive Medicine and Carol Opochinsky, Associate Professor, School of Nursing, University of Manitoba, are involved as advisors and content experts.

If you decide to participate in this investigation, I would like to ask you to complete a questionnaire which deals with different aspects of transcultural nursing, and your views/experiences with Indian Elders. A small section also deals with some aspects of your personal background, such as your formal education etc. This questionnaire will take approximately 20 minutes to complete. There are no right or wrong answers to these questions and the time you take to fill out this questionnaire should not unduly inconvenience you.

Any information that is obtained in connection with this research that could be identified with you will remain confidential and will be disclosed only with your written permission. The written report of this study will not refer to specific individuals or to specific locations (ie. nursing stations or health centres), or Indian Bands, and no individual will be identifiable.

Your decision whether or not to participate in this study will not affect your job or professional standing in your community. If you decide to take part in this study, you are free to discontinue participation at any time when filling out the questionnaire. If you decide to take part in this study, you will be assisting in research in an area of nursing that has not been previously explored.

If you have any questions you may contact the investigator, David Michael Gregory, BScN, RN, at [redacted] or in writing at the School of Nursing, Bison Building, University of Manitoba, Winnipeg, R3T-2M7.

The action of completing the enclosed questionnaire and mailing it back to the investigator indicates that you have freely consented to participate in this investigation. Please keep the "Cover Letter" and this "Consent Form".

Appendix K

SURVEY QUESTIONNAIRE FOR MEDICAL SERVICES NURSES

The following questionnaire will require approximately 20 minutes of your time. By completing this survey, you will be contributing to an area of nursing that has received very little research attention.

INVESTIGATOR: David Gregory, RN, BScN.
University of Manitoba,

Terms of Reference: Elder denotes an individual within the community who is influential and may possess official or unofficial power. This person is usually a senior citizen, but may be younger, ie: middle aged. Elders are usually respected and are often consulted by the leaders of the community (Chief and Council). Please note that many Elders are also traditional healers (medicine men/women).

QUESTIONNAIRE

CODE NUMBER_____

SECTION 1

This questionnaire is primarily directed at obtaining information related to the referral of clients/patients to Indian Elders for counselling purposes by MSB nursing personnel. Counselling includes offering advice or information regarding problems or difficulties within the client's personal or social milieu. Please circle the appropriate letter(s) for each question.

1. Have you ever referred clients/patients to an Indian Elder for counselling purposes?

   a. YES

   b. NO

2. If you answered YES to this first question, what were the results or outcomes of your client/patient referral to the Indian Elder?

   a. POSITIVE: The patient/client received relief or satisfaction with his/her problem.

   b. NEGATIVE: The patient/client did not receive relief or satisfaction with his/her problem.

   c. DON'T KNOW THE RESULTS OF THE REFERRAL

3. Would you, as a professional health care provider, be willing to collaborate with Indian Elders in the counselling of clients/patients?

   a. YES

   b. NO

   c. UNDECIDED

4. Would you refer a client/patient to an Indian Elder for counselling purposes if this practice was supported by your immediate superior(s)?

    a. YES

    b. NO

    c. DON'T KNOW

5. Confidentiality would be a factor in deciding whether to refer clients/patients to Indian Elders for counselling purposes. Circle your level of agreement or disagreement with the above statement.

    a. STRONGLY AGREE

    b. AGREE

    c. NEUTRAL

    d. DISAGREE

    e. STRONGLY DISAGREE

    f. DON'T KNOW

6. Communication barriers (ie. lack of understanding of Cree) would be a factor influencing your decision to refer clients/ patients to an Indian Elder for counselling purposes. Please circle the level of agreement or disagreement to this statement.

    a. STRONGLY AGREE

    b. AGREE

    c. NEUTRAL

    d. DISAGREE

    e. STRONGLY DISAGREE

    f. DON'T KNOW

7. Would you refer a client/patient to an Indian Elder for counselling purposes if your immediate supervisor disapproved of this action?

    a. YES

    b. NO

    c. UNDECIDED

    d. NOT APPLICABLE

8. Your own beliefs and knowledge about the social status and function of Indian Elders would be a factor in deciding to refer a patient/client for counselling purposes. Please circle the level of agreement or disagreement to this statement.

    a. STRONGLY AGREE

    b. AGREE

    c. NEUTRAL

    d. DISAGREE

    e. STRONGLY DISAGREE

    f. DON'T KNOW

9. Were you exposed to transcultural nursing concepts as part of your nursing education? (ie. supporting the client's cultural beliefs and values)

    a. YES

    b. NO

10. Do your past transcultural nursing experiences influence your present decisions in collaborating with Indian Elders or traditional healers?

    a. YES

    b. NO

    c. NOT APPLICABLE

11. Do you use transcultural principles/concepts (ie. supporting the client's cultural beliefs and values etc.) in your work?

    a. OFTEN

    b. SOMETIMES/OCCASIONALLY

    c. ALMOST NEVER

    d. NEVER

12. In general, do you think that Indian Elders are respected by their own people in your community?

    a. YES

    b. NO

    c. DON'T KNOW

13. Do you think that the Indian Elders are respected by the YOUTH in your community?

    a. YES

    b. NO

    c. DON'T KNOW

14. Have the Indian Elders in your community been identified to you?

    a. YES

    b. NO

15. Who identified the Elders to you? Please circle as many responses as needed.

    a. CHR

    b. NURSING COLLEAGUE

    c. NURSING STATION SUPPORT STAFF (ie. Cook, Clerk etc.)

    d. CHIEF

    e. COUNCIL MEMBER

    f. CLIENT/PATIENT

    g. TEACHER

    h. PRINCIPAL

    i. R.C.M.P.

    j. PRIEST/MINISTER

    k. DISCOVERED THEM MYSELF

    L. OTHER _____

16. Have the traditional healers (medicine men/women, shamans etc.) in your community been identified to you?

    a. YES

    b. NO

17. Who identified the traditional healer(s) to you? Please circle as many responses as needed.

    a. CHR

    b. NURSING COLLEAGUE

    c. NURSING STATION SUPPORT STAFF (cook, clerk, etc.)

    d. CHIEF

    e. COUNCIL MEMBER

    f. CLIENT/PATIENT

    g. TEACHER

    h. PRINCIPAL

    i. R.C.M.P.

    j. PRIEST/MINISTER

    k. DISCOVERED THIS MYSELF

    l. OTHER _____

18. Referring clients to a traditional healer (medicine man/woman) for treatment could possibly jeopardize your licensure as a nurse. Circle your level of agreement or disagreement with the above statement.

    a. STRONGLY AGREE

    b. AGREE

    c. NEUTRAL

    d. DISAGREE

    e. STRONGLY DISAGREE

    f. DON'T KNOW

19. To the best of your knowledge, are traditional Indian medicine practices currently being carried out in your community?

    a. YES

    b. NO

    c. DON'T KNOW

20. Have you ever referred a patient to a traditional healer for treatment?

    a. YES

    b. NO

21. Have your patients ever requested a referral to a medicine man/woman in your community or another community?

    a. YES

    b. NO

22. Collaboration between nurses and traditional healers would enhance the present health care services offered to Indian people. Please circle the level of agreement or disagreement with the above statement.

    a. STRONGLY AGREE

    b. AGREE

    c. NEUTRAL

    d. DISAGREE

    e. STRONGLY DISAGREE

    f. DON'T KNOW

23. Nurses should be informed as to who the traditional healers are in the community. Please circle the level of agreement or disagreement with the above statement.

    a. STRONGLY AGREE

    b. AGREE

    c. NEUTRAL

    d. DISAGREE

    e. STRONGLY DISAGREE

    f. DON'T KNOW

24. There are clients/patients in your community with minor mental health problems who could possibly benefit from the judicious utilization of Indian Elders. Please circle the level of agreement or disagreement with this statement.

    a. STRONGLY AGREE

    b. AGREE

    c. NEUTRAL

    d. DISAGREE

    e. STRONGLY DISAGREE

    f. DON'T KNOW

    g. NOT APPLICABLE

25. Would the counselling services offered by Indian Elders complement and enhance the existing health services offered to your patients/clients?

    a. YES

    b. NO

    c. DON'T KNOW

26. There are patients/clients in your community with social interaction problems (ie. marital discord, parent-child interaction) who could possibly benefit from the judicious counselling of Indian Elders. Please circle the level of agreement or disagreement with this statement.

    a. STRONGLY AGREE

    b. AGREE

    c. NEUTRAL

    d. DISAGREE

    e. STRONGLY DISAGREE

    g. NOT APPLICABLE

27. Would your immediate supervisor support the utilization of traditional healers (medicine men/women, shamans etc.) in the treatment of clients/patients?

    a. YES

    b. NO

    c. DON'T KNOW

    d. NOT APPLICABLE

28. Have you ever sought advice from an Indian Elder?

    a. YES

    b. NO

    c. NOT APPLICABLE

29. Have you ever incorporated the use of Elders into any of your public health programs?

    a. YES

    b. NO

    c. NOT APPLICABLE

30. Have you ever incorporated the use of traditional healers (medicine men/women) into any of your public health programs?

    a. YES

    b. NO

31. Do other resource persons (ie. Native Alcohol and Drug Abuse Counsellor, Alcoholic's Anonymous, Native Child Welfare Worker or CHR) utilize Indian Elders in their programs or activities?

    a. YES

    b. NO

    c. DON'T KNOW

    d. NOT APPLICABLE

32. If you worked in a non-Indian community, how would you view older people? Please circle as many responses as needed.

    a. RESOURCE PERSONS

    b. A DRAIN ON HEALTH CARE RESOURCES

    c. A SERIOUS HEALTH PROBLEM

    d. PERSONS OF AUTHORITY AND POWER

    e. A SPECIAL NEEDS GROUP

    f. DEPENDENT GROUP

33. Referring clients/patients to Indian Elders for counselling purposes could possibly jeopardize your licensure as a nurse. Circle your level of agreement or disagreement with the above statement.

    a. STRONGLY AGREE

    b. AGREE

    c. NEUTRAL

    d. DISAGREE

    e. STRONGLY DISAGREE

    f. DON'T KNOW

34. Would observing a nursing colleague refer a patient/client to an Indian Elder for counselling or a traditional healer for treatment influence your future decisions to collaborate with Elders/traditional healers?

    a. YES

    b. NO

    c. UNDECIDED

35. The orientation provided by Medical Services, pertaining to Indian culture was satisfactory.

    a. YES

    b. NO

    c. NOT APPLICABLE

36. The orientation provided by Medical Services, pertaining to traditional healers/Elders was satisfactory.

    a. YES

    b. NO

    c. NOT APPLICABLE

37. Would Medical Services nurses benefit from a more indepth orientation of Indian culture.

    a. YES

    b. NO

    c. DON'T KNOW

38. Did you find that you learned more about Indian culture once you were in your community?

    a. YES

    b. NO

    c. NOT APPLICABLE

39. The social status of Elders in Indian communities is more positive than the social status of the elderly in non-Indian communities.

    a. STRONGLY AGREE

    b. AGREE

    c. NEUTRAL

    d. DISAGREE

    e. STRONGLY DISAGREE

    f. DON'T KNOW

40. In general, Indian Elders have an excellent grasp of psycho-social dynamics. Please circle the level of agreement or disagreement with this statement.

    a. STRONGLY AGREE

    b. AGREE

    c. NEUTRAL

    d. DISAGREE

    e. STRONGLY DISAGREE

    f. DON'T KNOW

41. Do you feel that the Elders in your community trust you?

    a. YES

    b. NO

    c. DON'T KNOW

    d. NOT APPLICABLE

42. The length of time a nurse works in an Indian community may be a factor which contributes to the amount of local information (ie. who the medicine people are, or who the Elders are) which is divulged to the nurse.

    a. STRONGLY AGREE

    b. AGREE

    c. NEUTRAL

    d. DISAGREE

    e. STRONGLY DISAGREE

    f. DON'T KNOW

43. Do you feel that the Chief and Council should offer more information about their communities? ie: Identification and introduction to the Elders/Traditional Healers.

    a. YES

    b. NO

    c. UNDECIDED

44. Elders should be financially reimbursed for their counselling services. Please circle the level of agreement or disagreement with this statement.

    a. STRONGLY AGREE

    b. AGREE

    c. NEUTRAL

    d. DISAGREE

    e. STRONGLY DISAGREE

    f. DON'T KNOW

45. Is the knowledge of who the medicine men/women are in your community a secretive thing?

    a. YES

    b. NO

    c. NOT APPLICABLE

46. Has this information been readily shared with you?

    a. YES

    b. NO

    c. NOT APPLICABLE

SECTION II

You are more than half-way through the questionnaire. Please circle the appropriate number for each "condition" listed.

Indicate which of the following "conditions" could possibly benefit from a referral to an Indian Elder for counselling purposes.

		Strongly Agree		Neutral		Disagree Strongly Disagree
1.	Parent-child conflict.	1	2	3	4	5
2.	Discipline problems within the family.	1	2	3	4	5
3.	Minor Depression.	1	2	3	4	5
4.	Lack of self-worth.	1	2	3	4	5
5.	Marital discord.	1	2	3	4	5
6.	Alcohol/drug abuse.	1	2	3	4	5
7.	Child neglect.	1	2	3	4	5
8.	Child abuse.	1	2	3	4	5
9.	Wife/spouse abuse.	1	2	3	4	5
10.	Anxiety	1	2	3	4	5
11.	Diet Counselling (Traditional foods and breastfeeding)	1	2	3	4	5

12. Other (Please indicate any other condition(s) which could possibly benefit from an Elder referral.

_____

_____

_____

Some of the factors which may influence nurses PERCEPTIONS regarding collaboration with Indian Elders are listed below. Rank the factors (from greatest to least) which influence YOUR PERCEPTION of Indian Elders and ultimately your decision to refer patients/clients to the Elders.

1=greatest influence; 10=least influence

___ Influence of your own culture.

___ Your personality type (ie. independent, dependent)

___ Professional and/or personal goals.

___ Medical Services Policy

___ Cross cultural experiences

___ Knowledge/awareness of Indian Elders

___ Influence of significant others (ie ZNO, NIC etc).

___ Job orientation program

___Attitude of Elders towards the nurses

___Attitude of members of the community towards nurses

SECTION III

Thank you for answering the previous questions. This is the final section of the questionnaire. I would like to ask you a few questions related to your personal background. The answers you provide will be strictly confidential. Please circle the most appropriate letter.

1. Sex

   a. FEMALE b. MALE

2. Did you grow up in Canada?

   a. YES b. NO

3. Are you a Canadian Citizen?

   a. YES b. NO

4. Did you receive your basic nursing education in Canada?

   a. YES b. NO c. PARTLY

5. What is your nursing education background?

   _____ HOSPITAL DIPLOMA

   _____ BSCN/BN

   _____ MASTER'S

   _____ OTHER

6. What is the length of time you have been present in your community?

_____ month(s)

7. Have you worked in other Indian/Inuit communities?

a. YES b. NO

8. Have you had other cross cultural experiences. Please specify. (ie. Africa for 2 years...)

_____

_____

_____

9. Do you speak the local Indian language?

a. NOT A WORD

b. A FEW WORDS; SIMPLE PHRASES

c. MODERATE CONVERSATION

d. FLUENT

10. What is your age at the time of this questionnaire?

_____ (In years)

11. Who is your present employer?

a. MEDICAL SERVICES

b. CHIEF AND COUNCIL

Thank you for taking the time to fill out this questionnaire. I can sincerely appreciate how busy you are. I shall forward a brief summary of this study to the Zone Office or I can forward you a copy should you indicate in the space below with your address. Again, thank you so much!

Please place the questionnaire in the pre-stamped, addressed envelope and forward it to me no later than March 10, 1986.

Appendix L

LETTER REQUESTING RETURN OF QUESTIONNAIRE

303-475 Dysart Road
St. Andrew's College
Winnipeg, Manitoba
R3T-2M7

March 3, 1986.

Dear Nursing Colleague:

I am writing in order to thank you for participating in my research study. Your contributions will be most helpful in establishing those factors which influence nurses in collaborative efforts with Indian Elders. Your contributions will also help to substantiate the extent of contact between nurses and traditional healers. To date, I have a 50% response rate, and the data collection phase of my research is near completion.

If you have not had an opportunity to return your questionnaire, I would like to include your opinions and experiences since the small sample size makes all responses important. Thank you for participating in this study.

Sincerely yours,

David Gregory, RN, BScN.
Graduate Student
School of Nursing
University of Manitoba

Appendix M

NURSES AGE AND LENGTH OF STAY IN COMMUNITY IN RELATION TO CLIENT REFERRALS TO ELDERS/TRADITIONAL HEALERS

Age of Nurse	Referrals to Elders
20-25	5
26-30	5
31-35	4
36-40	4
41-45	4
46-50	2
51-55	1
55+	0

Age of Nurse	Referrals to Healers
20-25	2
26-30	6
31-35	4
36-40	3
41-45	2
46-50	1
50+	0

Time in Community and Number of Client Referrals Initiated by Nurses

Time in Community	Elders	Healers
1 month	1	1
2 months	3	2
3 months	1	2
4 months	2	2
5 months	1	0
6 months	4	2
7 months	1	0
8 months	1	1
9 months	1	1
10 months	1	1
11 months	0	0
12 months	1	1
12-24 months	5	3
25-36 months	2	1
36-48 months	1	1

Appendix N

IDENTIFICATION OF ELDERS AND ADVICE SOUGHT BY NURSES IN RELATION TO LENGTH OF TIME IN COMMUNITY

Time in Community	Elders Identified	Advice From Elders
1 month	2	0
2 months	3	1
3 months	2	1
4 months	3	1
5 months	2	1
6 months	4	3
7 months	1	1
8 months	2	0
9 months	2	1
10 months	0	0
11 months	0	0
12 months	1	1

Appendix O

CROSSTABLULATION OF VARIABLES USING FISHER'S EXACT TEST

Variable	p Value
1. Referral to Elders and exposure to transcultural nursing concepts.	.5364
2. Referral to Elders and identification of the Elders to the nurse	.1994
3. Identifcation of healers and their involvement in community health programs	.0033*
4. Other transcultural nursing experiences and referral to Elders.	.0577
5. Referral of clients to healers and identification of the healers to the nurses.	.1556
6. Identification of Elders and their involvement in community health programs.	.4669
7. Other transcultural nursing experiences and referral of clients to healers.	.3371

*Significant at =.05
Note: 2X2, df=1
Minimum cell size N=5