

Résumé

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**L'influence de la distance géographique  
et sociale sur l'exercice des soins infirmiers  
et la continuité des soins dans  
une communauté autochtone éloignée**

**Denise S. Tarlier, Annette J. Browne et Joy Johnson**

Le but de cet article est d'explorer, à partir des conclusions d'une étude ethnographique, l'influence de la distance géographique et sociale sur l'exercice des soins infirmiers et la continuité des soins dans une communauté autochtone éloignée du Canada. Les auteures ont eu recours à des sources de données multiples afin de situer leur analyse dans le cadre unique que constituent les services de santé au sein de la communauté à l'étude. Leurs conclusions révèlent que l'éloignement géographique, les conditions sociales inéquitables qui influent sur la santé et le bien-être de la population autochtone, de même que le degré de préparation des infirmières face aux exigences d'un environnement complexe, engendraient des modèles de distanciation sociale en matière de relation thérapeutique. Ces modèles restreignent la capacité des infirmières à adopter une approche qui favoriserait la continuité des soins. Dans certains cas, la distanciation sociale s'est traduite par des pratiques d'étiquetage de l'Autre et par un désengagement à l'égard des patients. Transformer les déterminants de la santé autochtone dans les communautés éloignées constitue un premier pas important vers l'adoption de pratiques infirmières susceptibles de favoriser la continuité des soins et d'engendrer des améliorations durables en matière de santé.

Mots clés : communautés autochtones, exercice des soins infirmiers, étiquetage, désengagement, continuité des soins, relation thérapeutique

# **The Influence of Geographical and Social Distance on Nursing Practice and Continuity of Care in a Remote First Nations Community**

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The purpose of this article, which draws on the findings of a larger ethnographic study, is to explore the influences of geographical and social distancing on nursing practice and continuity of care in a remote First Nations community in Canada. Employing an ethnographic design, the authors use multiple data sources to ground the analysis in the unique context of health services in the selected community. The findings suggest that remote geographical location, the inequitable social conditions that shape the health and well-being of First Nations people, and nurses' level of preparedness to practise in this complex environment fostered patterns of social distancing in nurse-patient relationships. These patterns constrained nurses' ability to engage in practice that promotes continuity of care. In some cases, social distancing took the form of Othering practices and relational disengagement from patients. Changing the social determinants of Aboriginal people's health in remote communities is an important first step in supporting the changes in nurses' practice that are key to improving continuity of care and to effecting long-term, sustainable health improvements.

**Keywords:** Aboriginal peoples, First Nations, remote communities, nursing practice, primary health care nursing, Othering practices, relational disengagement, continuity of care, patient-provider interactions

Patients who experience fragmented health care are often described as “falling through the cracks” of health services. These patients typically receive care from multiple providers, often at all three levels of care (primary, secondary, and tertiary), and are often seen by providers at frequent intervals yet fail to achieve either optimal clinical outcomes or optimal continuity of care. While fragmentation of care challenges the delivery of quality health services in all settings, it is particularly critical in the context of health-care delivery in geographically remote Aboriginal<sup>1</sup> communities.

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<sup>1</sup> The term Aboriginal is used to refer, in an inclusive sense, to indigenous Canadian populations (Royal Commission on Aboriginal Peoples [RCAP], 1996). These are people who identify or are recognized as First Nations, Inuit, or Métis. The study site was a First Nations community where the majority of residents had “registered” First Nations status; therefore, the term First Nations is used in this work when referring specifically to the

Residents of remote communities in Canada experience both poorer health and poorer access to health services than Canadians living in urban, suburban, or even rural settings (Romanow, 2002; Statistics Canada, 2003). While acknowledging that a broadly accepted definition of *remote* has yet to be established (Pitblado, 2005), researchers have typically attempted to clarify the meaning of *remote* and distinguish it from *rural* by adding geographical descriptors such as isolated, semi-isolated, northern, or outpost. Geographic descriptors establish, in a general conceptual sense, the physical and logistical barriers that influence health in remote settings, such as distance, poor access, a small population base, and relatively few resources and amenities. Residents of remote communities are further removed (in both time and distance) from the level of definitive treatment that is available in larger population centres, and thus lack the safety net implied by proximity to secondary- and tertiary-level health services. These patients are also more likely to be affected by health-care delivery issues such as high staff turnover, lack of supports and resources within the community, and difficulty recruiting and retaining highly qualified personnel (Fontaine, 2005; Minore et al., 2005).

Aboriginal people make up a large proportion, if not the majority, of Canadians who live in remote communities (Statistics Canada, 2001). Relative to other Canadians, Aboriginal residents of remote communities are more vulnerable to experiencing fragmented care because the health and social inequities that exert a profound effect on health status (Adelson, 2005; Canadian Institute for Health Information [CIHI], 2004; RCAP, 1996) place them at increased risk of falling through the cracks of health-care delivery. The relatively poor health of Aboriginal people compared to that of other Canadians is linked to marked social and historical inequities (Adelson; RCAP; O'Neil, 1986, 1989; Waldram, Herring, & Young, 2006; Young, 1984) resulting from the historical social, political, and economic relationships between Aboriginal people and European settlers.

When health-services researchers describe a community as remote, the implication is that its residents (a) are predominantly Aboriginal, (b) have poorer health, and (c) have access to fewer health resources in their community than do other Canadians. Remoteness may also imply that remote Aboriginal communities have in a sense fallen through the

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study site and the First Nations residents of that community. The more inclusive term Aboriginal is used when referring to the wider context of Aboriginal health or social issues or to issues that are relevant to Aboriginal people generally. No differentiation is made or implied between Aboriginal people with registered Indian status and those without. Use of the term Aboriginal is not meant to be inclusive of the Aboriginal or indigenous people of countries other than Canada.

cracks in relation to both health-service delivery and the dominant society: they are remote by virtue of being socially, economically, and politically removed from mainstream society. For example, Aboriginal communities are not included in the databases developed for non-Aboriginal Canadians (e.g., the Canadian Community Health Survey database); thus, it is easier to lose sight of their health status in comparison to that of other Canadians. Neither are they part of provincial health-care systems. Being geographically distant from the places where provincial health services are located, remote Aboriginal communities are forced to rely on a federal system that has, in theory, developed to meet their health-care needs in the absence of available provincial services (Waldram et al., 2006). The distancing and isolation of remote Aboriginal communities from mainstream society have as much to do with the historical and sociopolitical positioning of Aboriginal communities and populations in Canada as with geographical location (Adelson, 2005; Waldram et al.). Thus, there is a complex interplay between geographical context and the historical socio-economic and political contexts of Aboriginal people's health, and it has profoundly influenced the health and social status of Aboriginal Canadians.

The purpose of this article is to examine one important aspect of the findings of a larger ethnographic study. The main objective of the study was to develop a broad understanding of how nurses, as the principal providers of primary care in a remote First Nations community yet recognized as just one part of a complex health-care system, influence continuity of care and clinical health outcomes. A comprehensive discussion of the larger study, including quantitative health-outcome data, can be found elsewhere (Tarlier, 2006). In this article, we explore how geographical and social distancing interacted to influence nursing practice and continuity of care. We focus on the conditions and factors that shaped nurses' ability to contribute to continuity of care in their practice within the remote First Nations community where the study was conducted. We define social distancing as nurse-patient interactions that are characterized by a sense of disengagement originating in nurses' feeling of disconnection from the broader social context of the Aboriginal community and patients' lives.

### **Literature Review**

Some improvements in the health status of Aboriginal people have been achieved in recent years, attributable primarily to public health strategies such as improved housing and disease prevention (National Aboriginal Health Organization [NAHO], 2003; Romanow, 2002). However, significant health disparities persist, stemming largely from the social and

economic conditions that shape people's lives and well-being (Adelson, 2005). For example, chronic diseases such as diabetes (Green, Blanchard, Young, & Griffith, 2003; Waldram et al., 2006; Young, Reading, Elias, & O'Neil, 2000) and heart disease (Shah, Hux, & Zinman, 2000), infectious diseases such as hepatitis A (Jinn & Martin, 2003), tuberculosis (CIHI, 2004; Indian & Northern Affairs Canada [INAC], 2003), and traumatic death and disability (CIHI; INAC; Karmali et al., 2005; Young, 2003) continue to be significantly more prevalent in the Aboriginal population than in the general population. These health disparities are reflected in health-status indicators such as Aboriginal infant-mortality rates a third higher than the national average (Adelson; CIHI; INAC; NAHO). Significantly, these statistics are not simply neutral indicators of health and well-being but reflect the profound impact of social inequities and the social determinants of health on the health of Aboriginal people (Adelson).

In many remote Aboriginal communities, nurses (sometimes referred to as outpost nurses) are the main providers of primary health care, yet they often have little preparation, over and above basic nursing education, to practise in a role that is considered both expanded and advanced nursing practice and that has traditionally been and continues to be considered a nurse practitioner role (Gregory, 1992; Martin-Misener, 2000; Stewart & MacLeod, 2005; Tarlier, 2006; Tarlier, Johnson, & Whyte, 2003). Nurses are responsible for providing primary care as well as community health nursing, public health care, and, often, the non-nursing health services that in less remote settings are typically provided by a multidisciplinary team. As nurses are the principal and often sole providers of health services in remote Aboriginal communities, any exploration of health-care delivery in these settings necessarily implies an exploration of nurses' role.

Gregory (1988) notes the dearth of literature, particularly research-based literature, related to outpost nursing in Canada. Authors of more recent works have made the same observation (Chaytor, 1994; McLeod, 1999; Tarlier et al., 2003). Until recently, the outpost nursing literature that does exist focused largely on how nurses and nursing practice are affected by the same issues that typify remote and Aboriginal health care: isolation, lack of support and resources, and sociopolitical and historical context (Gregory, 1988, 1992; Martin & Gregory, 1996; Tarlier et al.; Vukic & Keddy, 2002). In remote Aboriginal communities, nurses — the vast majority of whom are non-Aboriginal — are often isolated not only from the personal, professional, and social supports they have left behind in their home communities “down south,” but from the Aboriginal community itself. Most nurses are unprepared for the “culture shock” (Gregory, 1992, p. 188) that can be experienced upon arriving in a

community that is unexpectedly foreign in terms of culture, social conditions, language, and, often, the embodied inequities that shape people's health status in many remote reserve communities. Vukic (1997) links difficulties in building trusting nurse-patient relationships at the practice level to the sociopolitical context: "the difficulty in part stems from the constraining, structural, administrative, historical, cultural and political realities that have shaped northern community nursing" (p. 542).

Few studies have focused on nursing practice in remote First Nations communities or on evaluating health outcomes as a result of nursing practices. A multisite case study of continuity of care in three First Nations communities in northern Ontario (Minore, Boone, Katt, Kinch, & Birch, 2002; Minore et al., 2005) used a structure-process-outcome framework and retrospective chart review to extract patient data on three selected health conditions. The findings suggested that poor health outcomes were related to discontinuity of care. Factors contributing to the lack of continuity were high turnover of nursing staff, inadequate preparation and education of health-care providers, the failure of primary care providers to carry out "holistic assessments" of patients (Minore et al., 2002, p. 21), lack of follow-up care, and failure of providers to communicate patient information to each other. Continuity of care was also viewed as related to the organization of the health-services system. By using continuity of care to link the process and outcomes of health-care delivery and to identify gaps in care, the study by Minore et al. (2002) carried out key foundational work that the present study, focused more specifically on nursing practice, builds on.

## **Method**

One of the key challenges in conceptualizing this research lay in recognizing that whatever nurses' practice might contribute to health in remote Aboriginal communities, it is only one of many health determinants, including geographical location and historical and social inequities, that shape health disparities. Inevitably, the geographical, economic, and social contexts in which people live and in which health care is delivered exert strong influences on the structure of health-services delivery, health outcomes, and continuity of care. These interrelated issues were explored using ethnographic approaches, which were well suited to developing a contextualized understanding of the conditions that shaped nurses' ability to promote continuity of care in practice.

### ***Conceptual Underpinnings***

Two conceptual models provided a framework for conceptualizing the study and for the process of data collection and analysis: the Nursing

Role Effectiveness Model (NREM; Irvine, Sidani, & McGillis Hall, 1998) and conceptual work identifying features of continuity of care (Reid, Haggerty, & McKendry, 2002). The NREM is an adaptation of Donabedian's (1980) work, made specific to nursing practice. Situating the NREM within a primary health care (PHC) framework helped to conceptualize how, in addition to nurses' practice, health services structures, process, and outcomes were influenced by the broader context of Aboriginal health.

The recent conceptual work by Reid et al. (2002) on continuity of care asserts that this is a multi-faceted concept that encompasses all three of the identified types of continuity: informational, relational, and management. Informational continuity involves the transfer of information and the accumulated knowledge about a patient. Relational continuity refers to both ongoing patient-provider relationships and consistency of personnel. Management continuity depends on coordination and consistency in the approach to treatment management and flexibility, or an individualized approach to care. Situating the work of Reid et al. within the NREM as it was adapted for use in this research facilitated an understanding of continuity of care as an outcome of health services and nursing practice. The adapted NREM offered a framework from which to develop the study protocol, which outlined in detail the data to be collected, the sources of data, and the methods of data collection and analysis.

### ***Data Collection***

The study was conducted at a purposefully selected site that met four pre-established selection criteria: (a) primary care was provided chiefly by nurses working in an expanded and advanced nursing role and within a PHC framework, (b) the population was greater than 1,000, (c) a minimum of four nurses were employed in a nursing station, and (d) the community was isolated both geographically and in terms of access to health-care providers other than nurses (i.e., no physician in the community on a continuous basis). A First Nations community that met these four criteria was located in the northern region of a western Canadian province. Support for the research and permission to conduct the study in the community were obtained from the community Chief and the Band Council. Support for and permission to conduct the study in the community's nursing station were obtained from First Nations and Inuit Health Branch (FNIHB) Regional headquarters and from the nurse in charge of the nursing station. Ethical approval was obtained from a university Behavioural Research Ethics Board.

Data collection took place during three visits to the community over a 6-week period in the autumn and early winter of 2004. Due to the

expense and logistics of travel and the lack of alternative accommodation, the researcher (the first author) was immersed full-time in the study site while in the community. The researcher had extensive experience as an outpost nurse working and living in similar communities in the region, which facilitated her access to the community and her engagement with the nurses, community members, and FNIHB administrators.

Data were collected from multiple sources, including observation of nurse-patient encounters, participant observation of the day-to-day operations of the nursing station (e.g., staff meetings; informal interactions among nurses, other health-care workers, and nursing station staff), observations related to the broader community, and artifacts (e.g., documents, photographs, maps of the community). Both audiotaped and informal interviews were conducted with nurses, other health professionals, and para-professional and nursing station staff members, including Community Health Representatives, administrators, and clerical and maintenance staff who resided in the community. Thus, several of the interviewees were also local community members. Observations, including brief conversations with patients related to their experience of health care and continuity of care, and informal interviews were recorded as field notes.

Data collection during interviews was directed by “guiding questions” that were initially formulated to explore participants’ perspectives on how nursing practice and continuity of care were shaped by contextual and structural factors such as isolation, access to resources, and working conditions, as well as the broader contexts of the community and the organization of health services. Brief conversations with patients during observations of nurse-patient encounters were guided by questions aimed at exploring their experience of continuity of care. Consistent with ethnographic interviewing, the interviews were continuously modified in the field in response to early interpretations of the emerging data.

The participants are described in Table 1. The demographic characteristics of nurse participants ( $N = 15$ ) are summarized in Table 2.

<b>Table 1 <i>Participants</i></b>	
	<b><i>N</i></b>
Nurses	15
Other health professionals	2
Para-professional and support staff	4
Patients:	34
Women	20
Children	14

	<b>Position</b>	<b>Education</b>
Female: 13; male: 2 Age: early 20s to mid-50s European or Asian ancestry: 13 First Nations: 2	Permanent staff: 7 Relief staff: 7 Orientee: 1	Diploma: 6 BN/BSN: 6 PHC skills course: 6 Community Health Nurse upgrade course: 3 Unknown: 3

The length of time interviewees had spent in the community ranged from lifelong in the case of First Nations community members to weeks or months in the case of relief nurses. Of the non-First Nations nurses, two had worked in the community for a range of 2 to 4 years. While a number of the nurses employed in a relief capacity had worked in the community for a relatively short period (from less than 1 month to a few months), the majority had worked in other remote First Nations communities for varying lengths of time that in a few cases added up to several years.

Data from the chart contents as a whole were also collected. These data, referred to as “contextual notes,” became a key part of the data set, providing a wealth of data that were particularly relevant to gaining an understanding of continuity of care at the study site.

### **Data Analysis**

Data analysis began in the field and was conducted concurrently with data collection. Initial analysis involved repeatedly reviewing the data, reworking, and rewriting, from jottings in the field to field notes that were continually expanded through the addition of interpretive memos. As key ideas were identified in the data, they were followed up and expanded upon in the field.

Data from each source were first analyzed independently using content analysis and subsequently interpreted in conjunction with the findings that emerged from other dimensions of the data set. The first level was based on a process of open coding and memoing, wherein data were coded line-by-line without reference to a priori theoretical assumptions (Emerson, Fretz, & Shaw, 1995). At a second, higher, level of analysis, data from the overall research process were analyzed thematically. The different levels of analysis undertaken for each data set were viewed not as discrete linear analytical events but as part of the iterative and ongoing development of ideas. Linking together the core themes and integrating

the findings of content analysis of each part of the data set facilitated the emergence of four over-arching themes. The adaptation of the NREM provided a conceptual structure within which to consider the three dimensions of continuity of care (Reid et al., 2002) that were used to guide analysis. These analytic strategies enabled a focused thematic interpretation of the data set as a whole.

### **Findings**

In this article we focus on the findings that were most relevant to understanding the interrelated nature of geographical and social location, and how it influences health, nursing practice, and continuity of care in the remote First Nations community where the study was conducted.

#### ***Nurses' Perceptions of the Remote Community: A World Apart***

When the nurse participants had first arrived at the study site, they understood that they were entering a community that was geographically distant from larger population centres. For the most part, they had expected that, because of its remote location and its First Nations population, the community would be “different” in some ways from the communities in which they customarily lived and worked. Indeed, several nurses noted that it was the difference, the opportunity to experience First Nations “cultures” and the sense of “adventure,” that had attracted them in the first place. Often, however, the nurses had not been prepared for the contextual contrasts they encountered on arriving in the community.

The community that served as the study site is located in the northern region of a western province, a 1- to 2-hour flight north of the nearest city. Like many remote communities, it is surrounded and isolated by water. It is accessible year-round by air, with daily scheduled service to and from the closest large service centre. However, transportation in and out of the community is often tenuous. Flights are sometimes “weathered out,” meaning that conditions prevent planes from landing or taking off. On any given day, high winds, storms, blizzards, fog, or extremely low temperatures may preclude flying. As in other northern communities, freeze-up and break-up present particular challenges to transportation within the community, as for 1 or 2 weeks each fall and again in the spring the ice is too thick to permit boat traffic yet not thick enough to allow people or vehicles to safely cross. The few roads in the community are unpaved and alternate between dust, mud, and ice, depending on the season. There are no sidewalks or shoulders to walk on. The dark forest grows right up to the verge, there are few streetlights to brighten the long stretches of road between buildings, and uneven

footing makes walking along the roads risky. Yet few residents own vehicles, so walking is a common mode of transportation.

In this particular community, the population varies between 2,000 and 3,000. The community's economic opportunities are limited, due to the long history of economic marginalization that affects many remote reserve communities in Canada, and its geographical location, far from any major industry or resources that could provide employment for a significant part of the population. Thus many residents are forced to rely on meagre social assistance payments as their main source of income. Less than 10% of the population is able to find full-time, year-round employment and the unemployment rate hovers around 30%, about five times the provincial rate of 6% (Statistics Canada, 2001). In 2001 the median average income of residents aged 15 and older was less than \$9,500, compared to more than \$12,400 for the province overall (Statistics Canada, 2001), and close to 40% of income earned in the community was government transfer payments (i.e., paid out largely as social assistance dispersed by local Band administration), versus 23% for the province as a whole (Statistics Canada, 2001). The community has both an elementary school and a high school up to Grade 12. However, barriers to high school completion persist: less than 2% of residents have been able to complete Grade 12. Of the residents who identified as First Nations, 97% spoke an Aboriginal language at home and 95% identified this as their first language (Statistics Canada, 2001).

At the time of the 2001 census, there were fewer than 500 houses in the community. Over 50% of these dwellings were more than 14 years old, over 40% were in need of minor repairs, and over 30% were in need of major repairs (Statistics Canada, 2001). This is a particular health concern, given Health Canada's (2003) definition of "adequate housing" as "housing units that do not require any minor or major renovations or replacement" (p. 65). Field observations suggested that more than one family in an extended family group reside in a small, two- or three-bedroom house. Local residents estimate that under 10% of houses in the community have running water, a condition of everyday life that is unknown to the majority of Canadians.

Both the First Nations community residents and the non-Aboriginal nurses frequently described the setting as "Third World." A nurse, who self-identified as First Nations and was a member of the community, described the conditions that many community residents lived with:

*Life is very difficult here. Running water and heat are big factors, in the morning especially, because people have to make a fire to warm up the house; sometimes when you go into the home early in the morning they're in bed just so they can stay warm. There are two or three families living*

*in one three-bedroom house. There's no running water, so hygiene is a factor. In some homes the water is frozen, so people have to build a fire and melt the water before they can wash up. Some of them don't change their clothes for a week because they don't have any water. How would they wash clothes? You need lots of water to wash clothes. They don't have dryers, they don't have towels to wash with, things like that. People don't eat properly because they're on a budget, on welfare. Their priority is to buy food.*

The lack of road access means that most goods are transported into the community by air, adding to the cost of groceries and basic supplies. One nurse described local costs as “exorbitant.” Field observations substantiated the high cost of basic necessities; for example, a case of infant formula (12 tins) cost \$58 (compared to \$26 for the same case in an urban centre), a box of disposable diapers cost \$35 (compared to less than \$20), and a box of laundry soap cost \$25 (compared to about \$8). Moreover, since the store is located across the water, far from where most First Nations residents live, transportation is by boat, or across the ice by foot, snowmobile, or vehicle. The water-taxi costs \$5 to \$8 per person one way, in a small open boat with no lifejackets on board; thus transportation is not only costly and inconvenient but also hazardous. The simple, everyday chore of purchasing necessities at the local store entails a degree of hardship that would be considered unacceptable in most Canadian communities.

Non-Aboriginal residents such as nurses, teachers, store personnel, and Royal Canadian Mounted Police officers, who together make up less than 1% of the population, have come to the community specifically to provide services. Therefore, notably, they are employed. Much of this 1% live together, segregated on one side of the water (the side where most of the services and resources are located), while the majority of the First Nations residents live on the “reserve side.”<sup>2</sup> In addition to having better access to local services, the small, mainly non-Aboriginal, off-reserve community enjoys noticeably better housing and roads that, while not paved, are at least graded and gravelled. Most of the nurses, however, live on the reserve side, where they are accommodated in a nurses' residence that provides a standard of living similar to what nurses are accustomed to in the south or in larger centres. Thus, the nurses enjoyed a substantially higher standard of living than most of their patients. In this remote First Nations reserve community, the historical sociopolitical context of

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<sup>2</sup> The word *reserve* refers to the Crown lands historically assigned to specific Aboriginal groups. The designation and assignation of Aboriginal people to reserved lands reflects the historic colonial subjection of Aboriginal people in Canada (Adelson, 2005).

Aboriginal people's lives has fused with the implications of geographical isolation to create a context of profound inequity in the social determinants of health.

### *Nurses' Practice in the Context of Difference*

Nurses' work, influenced by the broader community context of inequity and marginalization, occurred at the margins of mainstream nursing practice. Nurses newly arrived in the community found themselves in a world that was drastically different from the one they were accustomed to in urban or suburban, predominantly non-Aboriginal settings. The substandard housing, the lack of running water, the high cost of food, supplies, and transportation, and the reality of poverty within the community were among the contextual issues raised repeatedly by all participants, suggesting that little has changed since Gregory (1992) reported on similar findings 15 years ago. The First Nations health professionals and administrators who participated in this study clearly identified the need for non-Aboriginal nurses to be better prepared to work within the context, culture, and enculturated social conditions of a remote Aboriginal community. While most of the nurses had received a 3-week orientation, including an introduction to the isolation and the environment they could expect to find, they nevertheless felt unprepared. One recently arrived nurse stated, "*Nothing* prepares you for the reality of it."

For nurses, it was also a different world because the work expectations were quite different from those in the settings they were familiar with. Few perceived any part of their formal nursing education as having specifically prepared them to work as a primary care provider in a remote setting or in the context of Aboriginal health, cultures, and communities. This suggests that outpost nursing requires knowledge and skills well beyond what can be learned in basic nursing education programs. One participant felt unprepared for the reality of practice despite having several years' experience in acute critical care nursing: "I didn't really know what was expected of me until I got up here and saw — oh my god, this is what I've got to do. It freaked me out."

In addition to arriving ill-prepared for primary care practice, the nurses were faced with an exceptionally challenging patient population in terms of complex disease management and co-existing social and health issues. Community residents lived with everyday risk factors for poor health that would be considered unacceptable in mainstream communities, such as overcrowded housing conditions without running water. Nurses were expected to provide primary care in a setting that was defined not only by health and social inequities but also by an overwhelming burden of illness and injury. One nurse described her initiation

to the work as follows: "When I came here, everything seemed to be stressing me out. It was the isolation, being in a different culture... but the work aspect of it had me so stressed out that it was affecting everything else." Contextual and practice issues such as these contributed to a high turnover rate among nursing staff at this site. A review of relevant documents revealed that over 70 nurses had been employed in the nursing station in the 2-year period immediately preceding data collection.

Observational and interview data show that nurses were confronted daily with patient situations they felt helpless to remedy, such as children who were brought in for treatment of impetigo but who lived in a home without running water, or diabetic patients who could not afford to make healthier food choices. While nurses may have appreciated in theory the link between social inequities in the community and the health disparities they encountered on a daily basis, few of the nurses in this study possessed either previous experience in community health nursing or the knowledge and skills needed to address health issues at the community level. Thus nurses focused on what they felt they could manage, which was the day-to-day, task-oriented work of treating immediate health problems within a biomedical model of care, yet knowing that the treatment they were offering was often only a band-aid solution, given the root causes of poor health in the community. In discussing how nurses managed the broader challenges imposed by embodied health and social inequities, one nurse participant stated:

*Diabetes is a huge, complex health issue, and the nutrition is really poor, and the poor sanitation is another huge issue, and you see a lot of really preventable things come in the door, and some days it just seems like you see the same thing over and over and over again, and that's frustrating... we just deal with one situation at a time.*

Most nurses felt better prepared to respond to the prevalence and significance of poor health in the community by focusing on acute episodic care of patients at the individual level, rather than by approaching the issues that contributed to poor health from a more comprehensive community health nursing perspective. Nurses focused on treatment or curative services within a biomedical model, at the expense of health prevention and promotion activities within a PHC or community-development model. This suggests that they experienced role confusion related to understanding the broad, community basis of their nursing work. This dynamic allowed nurses to cope with their work environment, but it also fostered unintentional complacency about the prevalence of poor health and the issues that contributed to it. While most nurses appeared to link health with its social determinants in theoretical terms, at the practice level they often failed to link the prevailing

social and health conditions with patients' use of health services, which was in turn a reflection of continuity of care. For example, nurses often failed to see that social conditions in the community, such as lack of transportation or child care, presented challenges for mothers, who may have missed an appointment for prenatal or postpartum follow-up or for infant immunization. Nurses often ascribed behaviours such as failing to return for follow-up to a failure to take responsibility for one's own health. In effect, a degree of complacency blinded nurses to the health disparities that were the real health challenges facing their patients.

### ***The Effects of Social Distancing on Nursing Practice and Continuity of Care***

It became evident that the majority of nurses lived in the familiar world of the nursing station, remaining largely unaware of the unfamiliar world of the surrounding community. One First Nations nurse remarked that if non-Aboriginal nurses "come from a middle-class town or city that's quite different to here, they can't completely know what the reserve is like, so they never really get accustomed to it." Nurses encountered the realities imposed by the community context on a daily basis, yet they lived and worked within the protective bubble of the nursing station and residence, isolated and insulated from the community. Nurses were not really a part of the community or of the *other* world they associated with it; the local community was not *their* world. This paradox allowed nurses to maintain a distance from the reality they encountered in the clinic and in the community. As with previous research that identified nurses working in outpost settings as being "other" in the remote Aboriginal community (Tarlier, 2001; Vukic, 1997; Vukic & Keddy, 2002), distance between nurses and the community created space for nurses to remain disconnected from the community and disengaged from patients' lives.

Their disconnection and disengagement at the community level influenced nurses' engagement in health-care encounters at the individual level. Nurse-patient encounters suggest a process of relational disengagement, reflecting the challenges that influenced nurses' ability to engage in responsive relationships with patients (Tarlier, 2004). Othering, defined as a process of differentiation wherein people are set apart on the basis of perceived or supposed difference from the dominant culture (Browne, 2005, 2007; Johnson et al., 2004), was observed as contributing to nurses' disengagement from both the community and individual First Nations patients. These patterns of social distancing are complex. For example, the nurses experienced the process of Othering in relation to the community, yet at the same time engaged in a process of Othering themselves, from within the predominately non-First Nations environment of the nursing station.

Observational and interview data suggest that Othering is reflective of the difference that non-Aboriginal health-care providers perceived between their own worlds and the world of the local community. For example, one nurse who had relatively little experience working in remote First Nations communities remarked, "I don't think it matters how close you get or how much you're involved in the social activities; we're white, they're Aboriginal." As Browne (2005) points out, such framing of intercultural relationships in terms of "us"/"them" binaries (p. 79) reflects both "popularized assumptions" (p. 79) and racialized discourses that permeate social discourses in Canada and play a role in shaping many people's constructions of Aboriginal people. Thus, the Othering practices observed in the data represent individual nurses' mirroring of broader social discourses about Aboriginal people, rather than being an intentional or conscious effort to engage in practices or behaviours that reflect Othering. At the same time, the process of Othering affected the extent to which nurses were able to convey acceptance of and respect for the patients they encountered in the nursing station. Othering thereby mitigated the formation of responsive nurse-patient relationships and contributed to a sense of distance between nurses and patients. According to Reid (2002), the strength of the relationship between patient and provider (or provider teams), which includes characteristics such as respect, trust, communication, and comfort, is an important aspect of relational continuity of care. Thus, distance in interpersonal relationships compromised relational engagement, which was the linchpin holding together the process of providing care and informational and management continuity.

In the absence of relational engagement, the process of care was characterized by a sense of disengagement within nurse-patient encounters, which was one factor creating gaps in continuity of care. The consequences of disengagement, and its influence on continuity of care, can be significant; for example, as reported elsewhere, such patterns of relating and gaps in continuity of care can have discernable effects on maternal-infant health outcomes (Tarlier, 2006). Thus, geographical and social distancing interact to influence nursing practice and, in turn, continuity of care.

## **Discussion**

At the meso and micro levels of health-service delivery, community relations and nurse-patient encounters in the context of this remote community magnified the ways in which Othering practices contributed to social distancing (also described in Browne, 2005, 2007, and Tarlier, 2004) and constrained the extent to which continuity of care could be enacted in everyday nursing practice. At a societal level, Othering perpet-

uates social inequities and marginalizing practices in health care (Browne, 2005, 2007; Browne & Fiske, 2001). Clearly, it is important that these issues, particularly the role of social distancing, be considered in relation to continuity of care in geographically isolated Aboriginal communities, where health disparities are greatest.

Nurse-patient encounters do not occur in a vacuum but are situated within a context that influences both nurses and patients. In remote Aboriginal communities, context is shaped by the implications of being geographically distant from the resources, supports, and amenities that are taken for granted by most Canadians and by the social and historical realities and conditions that inform the social location of Aboriginal people in Canada. Moreover, the system of delivering health services to Aboriginal Canadians is situated within and structured by the historical and sociopolitical context of Aboriginal health. Each of these contexts influences the unfolding of nursing practice in ways that have implications for the health of the residents of remote First Nations communities.

Conceptualizing nursing practice and continuity of care within a PHC framework serves to highlight these links among the social and environmental contexts, the structure of health services, and the processes of achieving continuity of care and health. PHC enables a broad view of the multiple factors — both within and external to the health-care system — that influence health (O’Neil, 1986). While the present findings suggest that specific aspects of context shape nurses’ practice in a remote First Nations community and their ability to influence continuity of care, the conceptual underpinnings of the study serve to remind us that no single circumstance can be identified as “causing” the findings related to continuity and health outcomes.

Health-services researchers postulate that improving continuity of care serves to decrease fragmentation of care (Haggerty et al., 2003; Sparbel & Anderson, 2000). If fragmented care is exemplified by the idea of patients “falling through the cracks” of health-care delivery, continuity of care may be represented by the idea of ensuring the safe and efficient passage of patients as they navigate the health-care system. In the context of nursing practice in remote Aboriginal communities, improving the ability of nurses to contribute to continuity of care represents a critical strategy for improving health.

Based on the three aspects of continuity of care identified by Reid et al. (2002), the findings of this study reveal that gaps in continuity (Tarlier, 2006) were influenced by factors in the context, structure, and processes of health-services delivery at the study site, as well as by factors within nursing practice. For example, management continuity was often compromised by nurses’ lack of preparation to provide community-based primary care in a First Nations community, which was in part attribut-

able to the unavailability of appropriate educational opportunities at the organizational level. Informational and relational continuity were affected by the high staff turnover and the inconsistency of staffing at the organizational level and by relational disengagement between nurses and patients at the individual level.

The process of Othering acted as a barrier to nurse-patient engagement and the formation of respectful, responsive relationships between nurses and individual patients. Similarly, in a study of First Nations women's beliefs about prenatal care, Sokoloski (1995) identified the discriminatory attitudes of health-care providers as a barrier to prenatal care; First Nations women were more likely to be satisfied with care and to attend prenatal visits when health-care providers engaged wholly with them during interactions. In the present study, as in Browne's (2005, 2007) study of encounters between nurses and First Nations women, nurses did not intentionally or even consciously engage in Othering practices. However, their lack of insight related to Othering practices contributed to distance in nurse-patient interactions, precluding the formation of engaged, responsive relationships with patients and possibly inadvertently compromising patients' use of health services and thus the continuity of care.

One of the external factors identified by Donabedian (1980) in his original work applying the structure-process-outcome framework to evaluation of health services was inequity in the social valuation (and thus access to health services) of "different segments of the population" (p. 16), or, in contemporary language, populations that are marginalized by social and health inequities. As Donabedian suggests, and as the present findings confirm, the structure and processes of health care do not imply singular cause-and-effect relationships; rather, they imply a web of multi-causal interrelationships that are shaped by the complex inter-workings of multiple health and health-care influences.

In its most essential definition, PHC has the expressed goal of enabling populations to achieve equitable health by effecting meaningful and sustainable change in the social and economic dimensions that influence health. The social inequity and marginalization that emerged as the contextual backdrop of this study must be addressed through broad health-policy changes guided by the PHC principles set down by the World Health Organization (1978). Health policy — and the delivery of nursing care within communities — must be realigned to better reflect the essential philosophy and spirit of PHC. Initiating new structures within federal health policy-making that give Aboriginal people a greater voice in policy formulation at the highest levels is congruent with the philosophical mandate of PHC and is a necessary step in breaking the grip of a system that has never really been freed of its colonial roots.

For nurses to become fully invested in the process of creating change in the context of Aboriginal health, they must have the knowledge and skills needed to support their role as brokers of a PHC model, in the unique yet diverse contexts of practice they will encounter in remote Aboriginal communities. Nurses' practice in these communities calls for a profound understanding of the principles of PHC and community development, as well as knowledge related to the historical and contemporary sociopolitical contexts of Aboriginal health, the social dynamics that underlie the process of Othering, issues related to geographical location and health, and cultural safety. This is no small challenge, given that nursing education tends not to focus on the sociopolitical context of health or health-care inequities, marginalizing practices in health care, or the complex processes of Othering (Browne, 2005). However, this kind of knowledge would enable nurses to develop an awareness of the multiplicity of complex factors and social conditions that affect the health of Aboriginal people. Fostering a strong foundation of clinical knowledge is equally important if nurses are to strive towards improving continuity of care in Aboriginal communities; nurses require advanced nursing practice skills as primary care providers in order to provide effective and efficient primary care and to engage effectively with patients. This is particularly true for nurses working in communities where geographical and social distances call for a multiplicity of skills, knowledge, and nursing competencies.

As the present findings suggest, nursing practice in remote Aboriginal communities is broad and complex and requires formal knowledge and skills that are not only beyond basic nursing education but also beyond nurses' usual informal experiential learning. By better understanding their role as primary care providers working within a PHC model of health, nurses will be better positioned not only to exert a positive influence on continuity of care and health outcomes but also to facilitate change in the broader picture of health determinants that so profoundly influence health in remote Aboriginal communities. There is an urgent need for research on the development, delivery, and evaluation of formal educational opportunities to prepare nurses for practice in remote Aboriginal communities, as well as research to further explore and substantiate the relationships between nurses' preparation, continuity of care, and health outcomes. In keeping with the fundamental principles of PHC, future research should also focus on incorporating the perspectives of Aboriginal stakeholders, including those at the local community level.

It is time to critically examine the policies and structures that have shaped both Aboriginal health services and the preparation of nurses to provide care in remote Aboriginal communities, to rectify those policies and structures that support or perpetuate the inequitable delivery of

services and strengthen and build upon those that support the fundamental principles of PHC and that effect change in the social determinants of the health of Aboriginal people. Such actions will support the changes to nursing practice that are key to improving continuity of care and to effecting long-term, sustainable improvements in both health and nursing practice in remote Aboriginal communities.

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