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Spirit of the Drum: The Development of Cultural Nursing Praxis

Pertice Moffitt and Judith Wuest

L'intégration de la culture est une dimension essentielle de la formation en sciences infirmières et de la pratique auprès de populations variées. Les enseignantes et les étudiantes qui évoluent dans des classes multiculturelles doivent adopter des comportements sensibles aux différences, qui valorisent l'identité culturelle et l'importance des soins adaptés à celles-ci tant dans la salle de classe que dans le milieu clinique. On a eu recours à l'évaluation de quatrième génération décrite par Guba et Lincoln pour évaluer le volet culturel d'un programme en sciences infirmières offert dans le Nord canadien. Les résultats indiquent qu'il faudrait adopter un processus d'intégration des différences par l'intermédiaire de la relation infirmière-client, ainsi que des manières d'être. L'article traite également des implications que comporte, pour la formation et la pratique en sciences infirmières, l'intégration de la politique en matière de savoir-faire culturel du gouvernement des Territoires du Nord-Ouest, telle que décrite dans le *Northern Knowledge Model*.

Mots-clés : savoir-faire culturel, intégration de la culture, formation

The integration of culture is essential for nursing education and practice with diverse populations. Educators and students in the multicultural classroom must adopt culturally responsive behaviours that validate cultural identity and enhance cultural caring both in the classroom and in clinical areas. Fourth-generation evaluation as described by Guba and Lincoln was used to evaluate the cultural curriculum of a nursing program in northern Canada. The findings suggest that we should adopt a process of integrating difference through the nurse-client relationship and ways of being. Implications for including the traditional knowledge policy of the government of the Northwest Territories in nursing education and practice, as depicted in the Northern Knowledge Model, are discussed.

Keywords: cultural competence, integration of culture, cultural evaluation, education

Although culturally competent nursing care is of fundamental importance to nursing practice (Campinha-Bacota, 1999; Meleis, 1996; Purnell & Paulanka, 1998), little research has been conducted on the ways in which culture is integrated in nursing practice and what constitutes culturally appropriate care for subarctic aboriginal people. Such knowledge is paramount when working in Canada's Northwest Territories,

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where the majority of clients are indigenous and the majority of health-care providers are white mainstream Canadians. In this paper, we provide an overview of the findings of a qualitative participatory study conducted in a northern community to evaluate the ways in which and degree to which recently graduated nurses integrate culture into their practice, and to determine what is and what is not effective in facilitating the learning of culturally appropriate care.

Literature Review

Most of the research and theoretical literature to date has focused on identifying the beliefs, values, and traditions of specific cultures and on developing assessment tools that will assist nurses in providing care that is culturally sensitive and appropriate (Andrews & Boyle, 1999; Davidhizar & Giger, 1998; Leininger, 1995). Cultural competence has been proposed as a process for guiding nurses towards culturally appropriate outcomes (Campinha-Bacote, 1999; Purnell & Paulanka, 1998). Cultural brokerage has been described as a way of reconciling diversity and resolving conflict (Jezewski, 1995; O'Neil, Koolage, & Kaufert, 1988; Paine, 1971). Jezewski defines culture brokering as "the act of bridging, linking or mediating between groups or persons of differing cultural systems for the purpose of reducing conflict or producing change" (p. 20). Transcultural education has been either invisible or fragmented in most nursing programs in Canada (Guruge, 1996; Srivastava & Leininger, 2002), with limited investigation into evaluation of cultural learning (Barton & Brown, 1992; Kulig & Thorpe, 1996; Pope-Davis, Eliason, & Ottavi, 1994).

A literature review of culture, transcultural education, the integration of theory into practice, and the evaluation of cultural learning resulted in unanswered questions. What are the processes in which culture is integrated into practice, and is culture brokering one of these processes? What are the influences on teaching and learning that culminate in a culturally competent nurse? Are there steps to becoming culturally competent, or degrees of competence exhibited by nurses? Are these influences similar or different for multicultural nurses in a multicultural environment? Through collaboration with a northern nursing program, the first author sought answers to these questions using a participatory evaluation approach.

Methodology

Fourth-generation evaluation (Guba & Lincoln, 1989) was chosen as the method for evaluating the cultural component of a northern nursing

program because it is an interactive, dialectic approach that engages all stakeholders in reaching a consensus regarding the "evaluand" — in this case, cultural care. Using a circling process, the researcher (a) explores the different views of the stakeholders, (b) summarizes the different constructions for each stakeholder group, and (c) develops a consensus on the emergent construction through several negotiations, first at an individual group level and then in a group that includes representatives from all stakeholder groups.

In this study, the three stakeholder groups were faculty members (both full-time and part-time instructors), nurses who had graduated in the previous 2 to 3 years, and northern residents who had recently received nursing care. Of the 16 participants in the three stakeholder groups, four were Dene, four were Inuit, two were Metis, one was Filipino, and five were Caucasian. Recruitment took three forms. Faculty members voluntarily completed a participation form after attending a meeting at which the first author described the research project and the process. Graduates of the program were sent a letter describing the study with a form to submit if they wished to participate; as forms were received they were numbered and the first five became the graduate stakeholder group. Clients were recruited from a family practice clinic; two of the five people who submitted forms were unable to participate for personal reasons, so two more participants were acquired through a snowballing technique. All participants who agreed to be part of the research signed an informed consent form.

Initial questions were established for each group of stakeholders, with more structured questions following as the constructions emerged. Clients were asked: If someone asked you about your culture, what would you tell them? What sort of questions should I ask to learn about someone's culture? How does a nurse show consideration for your culture while caring for you? Faculty members were asked: How would you define culture? What processes within the curriculum address culture? What do you do to help students develop culturally appropriate behaviours? Graduates were asked: What does culture mean to you? Describe how you incorporate culture into your nursing care. Tell me about some experiences with clients which took into account specific cultural care.

In each stakeholder group, each member participated in an audiotaped interview that was transcribed and analyzed line by line for central themes before the next member was interviewed. In this way the researcher was able to not only gain the next participant's perspective but also get his/her feedback on the emerging construction.

Key claims, concerns, and issues regarding cultural care were gradually identified through constant comparison among themes in the interviews, and these became the focus of the stakeholder group meetings where differences were negotiated. After several meetings, agreement was finally reached among all stakeholder groups.

Findings

Two models were generated from the circling process and layers of constructions. The first model, the integration of culture (Figure 1), addressed the research question *In what ways do graduates integrate culture into nursing practice?* The second model, northern knowledge and nursing (Figure 2), addressed the question *What is and is not effective in facilitating the learning of culturally appropriate care?* Figures 1 and 2

Figure 1 *Integration of Culture*

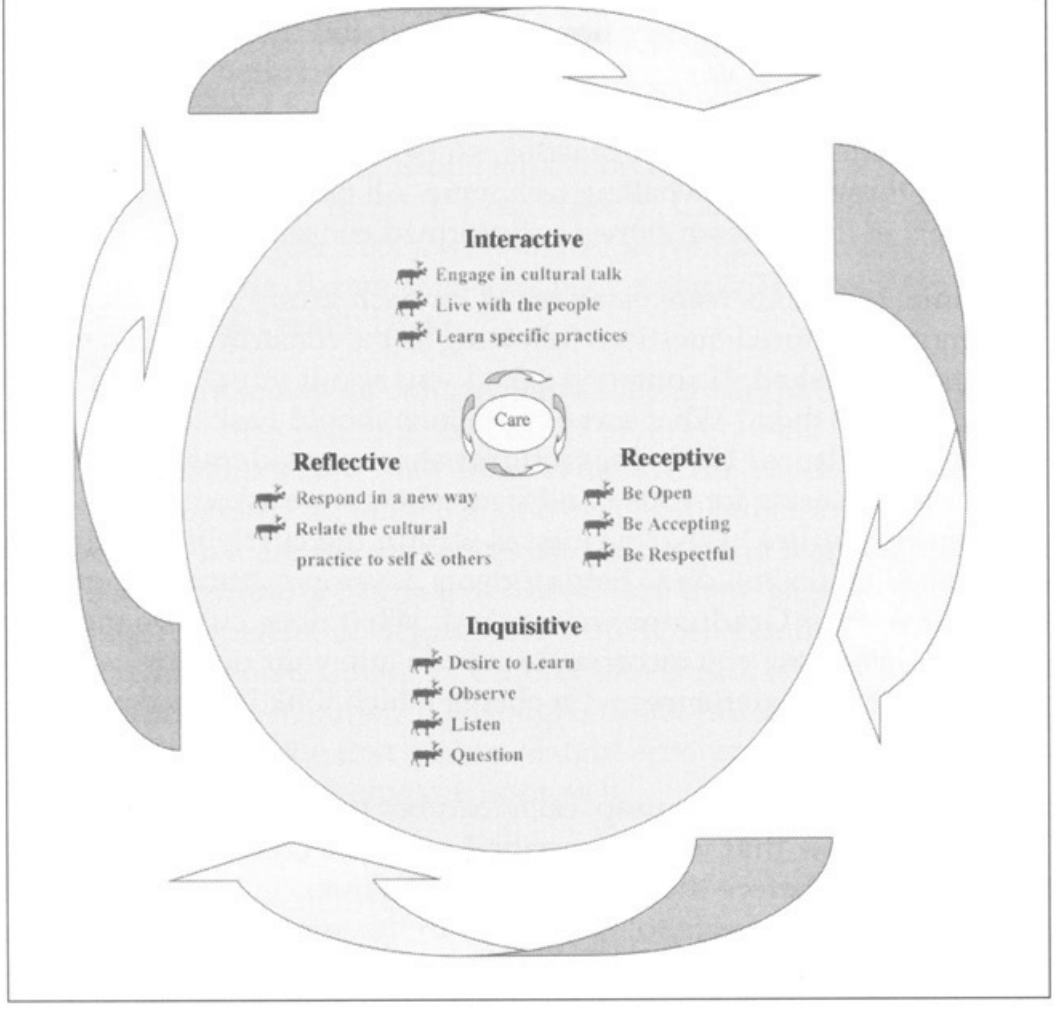
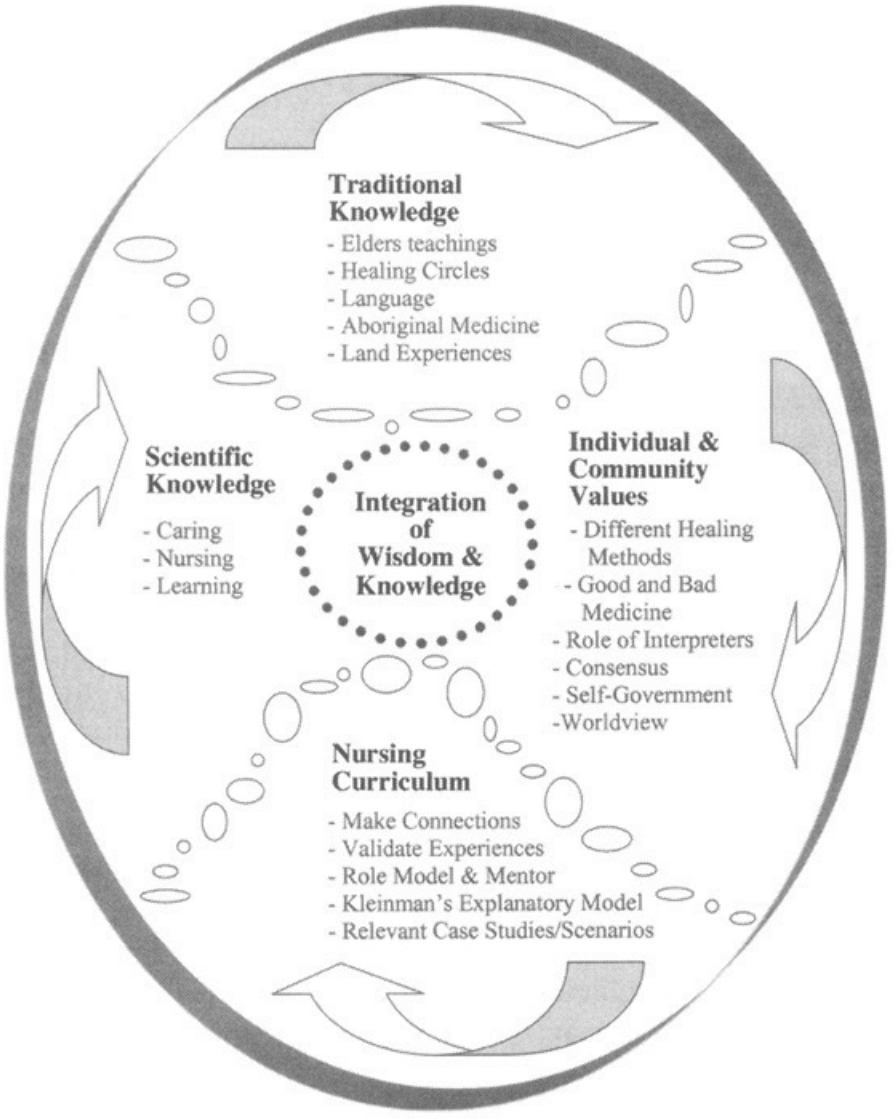


Figure 2 *Northern Knowledge and Nursing*



were derived from the claims, concerns, and issues identified in the data and validated by the participants. The figures went through a process of reconfiguration at the group meetings, with final validation coming from representatives of all three stakeholder groups.

The Process of Integrating Culture

The integration of culture was viewed by the participants as the integration of difference. It was depicted as a circle because of the signifi-

cance of the circle to the participants and as a principle integral to aboriginal people (Bopp, Bopp, Brown, & Lane, 1988; Hart, 1996; King-Hooper, 1991; Riddington, 1988). The circle suggests harmony and balance in native education, with each learner being equal and interdependent — a part of the whole in terms of life and the entire universe (Hanohano, 1999). The drum, too, is framed within a circle, and hence the spirit of the drum is captured in the integration of culture. Drum-making has been used for several years in the Northern Nursing Program as a way of teaching indigenous culture. As well as providing instruction in the creation of the drum, the elder teaches new songs, which, once played, will always be in the drum; in the same way, new cultural information is accumulated, learned, and then applied in nursing practice.

There are four *ways of being* within the process of the integration of culture. These were identified and validated by the participants as *inquisitive, receptive, interactive,* and *reflective.* These *ways of being* are situated in the four directions of the circle. The directions depict the opposing forces that are present when difference is experienced. Within each *way of being* are strategies that, when employed, increase the extent to which the direction will move the individual towards integration. The model thus illuminates descriptive nursing behaviours that will foster culturally appropriate practice.

Inquisitive way of being. The desire to learn, the desire to observe, the desire to listen, and the desire to question are four elements shaping the inquisitive way of being. The desire to learn is manifested through attentiveness. By observing, listening, and questioning, the nurse comes to culturally know the client, and by determining the client's "situatedness" the nurse can accommodate that person. For example, if the semantics of the local dialect are not considered and thoroughly explored, cultural conflict can result, as illustrated in the practice of one participant when she was studying the Dogrib language:

> *I said to the Dogrib teacher, "Okay, I want a glass of orange juice. What word would you use?" She said, "You know that." And I said, "No, I don't...I know orange, jeik'o. I know orange, but I don't know juice." She said, "ti." And I said, "jeik'o ti...no, that is orange water." She said, "That is orange juice." And I said, "Oh, hold it, if I ask for orange crush...jeik'o ti...if I ask for orange juice...jeik'o ti." And I said, "We are doing nutrition counselling through an interpreter and we are wondering why there is orange crush in a baby's bottle."*

Receptive way of being. The receptive way of being is one of openness, acceptance, and respectfulness. An aboriginal woman explained the significance of "smudging" to becoming open in her culture:

> *You clean your eyes so that you can see with the eyes of a baby. You clean your ears so that you can hear what is really being said. You clean your mouth so that the words that come out are words of understanding. And you clean your heart so that you can care.*

In this way, you are being receptive. Other participants described it as being "being present," "being unassuming," and "not sitting in judgement." Through acceptance, a rapport is developed. Respect is a salient element in the receptive way of being. Participants in the study used "smile at me," "welcome me," "shake my hand," and "don't laugh at me" as expressions of respect and openness to understanding the culture.

Interactive way of being. Engaging in cultural talk, living with the people, and learning specific practices are elements moulding the interactive way of being. When people engage in cultural talk, there must be a sharing of information until understanding is reached; the message must hold the same meaning for each person involved in the interaction. Cultural talk is relevant for exploring the values, beliefs, and practices that are significant to the individual. Living with northern people and experiencing their way of life "actualizes" this process. One participant shared a story about a client with whom she was working:

> *One of her requests was [that] if a female was menstruating, she wasn't allowed to give her care or enter the room and there was a sign on the door that said that. She didn't last very long. She passed away within a couple of months. But that made her feel better...she felt better after seeing the medicine woman and taking that advice, and a lot of us on the floor were sensitive to that — mind you, there were some that thought it was a whole lot of hocus-pocus.*

Reflective way of being. The nurse and the client reflect on the cultural knowledge that emerges through the nurse-client relationship by relating it to their existing personal and practice knowledge, to the present situation or context, and back to the self. By reflecting on the cultural encounter, the nurse and client consider the similarities and differences when relating the new knowledge to their personal knowledge. By virtue of acknowledging the disparity, they are able to consider the meaning of the differences and resolve any conflict that may have resulted. One participant described it this way:

> *I went to do a Denver in the Inuit culture and we were doing the opposite of high and the clerk interpreter said, "I can't ask that." So I said, "Is there such a word?" She said, "Yes." "And is there such a word for low?" And she said, "Yes, but they are not opposite... High exists. Low exists. Who says they are opposite?" Our language says they are opposite. Our ways of categorizing cultural constructs say they are opposite.*

The Northern Knowledge Model

Northern knowledge is described in the corporate plan of Northern College as comprising traditional knowledge, scientific knowledge, and individual and community values. The participants in the present study adopted this model during the process of reaching consensus on how nurses learn culturally competent care (see Figure 2). The model identifies content areas for the curriculum and relevant teaching and learning principles for the nursing program.

Traditional knowledge, in the context of the present study, is the recognized accumulated wisdom of the aboriginal people of the Northwest Territories. The inclusion of traditional knowledge, along with Western scientific knowledge, in the epistemology of northern nursing allows for a valuing of both student and client populations. Some of the strategies identified in this study are teaching and mentoring by elders, learning on the land, using sharing circles, teaching and incorporating traditional medicine and spirituality into learning, and acknowledging and responding to the different languages of the people.

Individual and community values are salient to the health and healing of specific groups. The participants in this study believed that learning about the worldview of others is essential to becoming aware of difference and developing a greater sense of awareness in general. We need to become cognizant of who we are by examining our personal belief systems and identifying our cultural biases in order to comprehend and respond to the realities of our clients. To be effective cultural caregivers in the Northwest Territories, we need to be sociopolitically, historically, and culturally astute. To do so we must incorporate knowledge of different healing methods, good and bad medicine, the role of interpreters, and self-government and consensus practices into our nursing practice.

Summary and Implications

In summary, implications for the enhancement of the cultural component of the nursing program were discovered and are presented in the Northern Knowledge Model, which identifies elements of traditional knowledge, individual and community values, scientific knowledge, and culturally appropriate ways to facilitate teaching and learning in a multicultural setting. The implications for education are the inclusion of difference and traditional knowledge in the multicultural classroom and practice settings through open dialogue, sharing circles, cultural

conflict resolution, and the development of relationships based on the integration of the cultural model. In practice, an emphasis should be placed on relationship development that sees each client as unique and different, requiring care that is based on difference rather than sameness. Caring relationships based on respect are central to a multicultural environment.

Future research areas prompted by this study include (a) the exploration of nursing relationships using the integration of difference model, and (2) the exploration of teachers' role-modelling of cultural caring and its effect on the integration of culture. The Northern Knowledge Model constructed in this study could be used to guide the curriculum, followed by re-evaluation in order to assess its effectiveness in instilling culturally appropriate student behaviours.

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