
Achieving Cultural Integration in Health Services:

Design of Comprehensive Hospital Model for Traditional Healing, Medicines, Foods and Supports

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ABSTRACT

Genuine cross-cultural competency in health requires the effective integration of traditional and contemporary knowledge and practices. This paper outlines an analytical framework that assists patients/clients, providers, administrators, and policy-makers with an enhanced ability to make appropriate choices, and to find pathways to true healing while ensuring that the required care is competently, safely and successfully provided. Examples presented are primarily based on experience of the Sioux Lookout Meno Ya Win Health Centre (SLMHC), which serves a diverse, primarily Anishinabe population living in 32 Northern Ontario communities spread over 385,000 sq. km. SLMHC has a specific mandate, among Ontario hospitals, to provide a broad set of services that address the health and cultural needs of a largely Aboriginal population. We will outline our journey to date towards the design and early stages of implementation of our comprehensive *minoyawin*¹ model of care. This includes an evaluation of the initial outcomes. This model focuses on cross-cultural integration in five key aspects of all of our services:

- Odabidamageg (governance and leadership).
- Wiichi'iwewin (patient and client supports).
- Andaw'iwewin (traditional healing practices).
- Mashkiki (traditional medicines).
- Miichim (traditional foods).



The paper outlines a continuum of program development and implementation that has allowed core elements of our programming to be effectively integrated into the fabric of all that we do. Outcomes to date are identified, and potentially transferable practices are identified.

KEYWORDS

Traditional healing and medicines, Aboriginal health, cross-cultural competency, transcultural care, integrative medicine, Anishinabe

INTRODUCTION

The Sioux Lookout Meno-Ya-Win Health Centre (SLMHC) has a specific mandate, among Ontario hospitals. It is to provide a broad set of services to a largely First Nations service population in a manner which addresses both health status and cultural needs. As SLMHC develops programs and services that respond to this mandate, it is expected that it will emerge as an Ontario center of excellence in the provision of culturally sensitive care.

Eighty-five per cent of our patients are predominantly Anishinabe people. Many of our patients use English primarily as a second language. These same patients live in a cultural context that results in Sioux Lookout, let alone Thunder Bay, Winnipeg or Toronto being experienced as “foreign” environments with major linguistic and cultural barriers encountered. The operations and settings of the health care system are complex, and equally “foreign.” This requires sensitive support and assistance for the system to be beneficially navigated, and for services provided to be fully effective.

Access to services is often a logistical nightmare for both patient and provider, e.g. the majority of northern patients access SLMHC by fixed wing air transportation. There is a need for special support mechanisms, some of which are the direct responsibility of the hospital. Non-Insured Health Benefit (NIHB) supports, including escorts, may be available to the point of entering the hospital for services. SLMHC is responsible beyond that point until the patient is returned to the NIHB-funded setting. This often includes patients and family who are traumatized by the logistics of getting to the service point, in addition to having to deal with the presenting health issue(s) and the “foreign” context in which they are met.

This article outlines a Traditional Healing, Medicines, Foods and Supports (THMFS) program developed by SLMHC to ensure that these services are provided in

response to this mandate, and on a basis that supports cross-cultural competency and safety requirements of the organization. The program development process and underlying research are also outlined. The program is in early stages of implementation, with complete adoption planned for 2010/2011, when our new facility is complete. The model of care arose from *Bi maa dizi win*, a 2005 multi-faceted research project involving consultations with Elders, community focus groups and visits to other successful Aboriginal programs.

The THMFS program is a new model for integrated First Nations hospital-based services, and will serve as a substantive prescription for progress in addressing the illness burden of Ontario's most at risk population: the people living in our northern First Nations communities.

The program responds to all key aspects of a multi-dimensional cross-cultural patient safety analytical framework developed by SLMHC in 2005. It is congruent with the increased emphasis by the Canadian Council on Health Services Accreditation (CCHSA) and the Canadian Patient Safety Institute on formalizing patient safety programs.

LITERATURE REVIEW

Cultural Safety

Developing out of Leininger's (1975) model of “trans-cultural nursing,” the concept of “cultural safety” was introduced by Ramsden (1993) in the nursing education context of New Zealand (Smye, 2002). Cultural safety is used as an analytical tool to understand the everyday social interaction between caregiver and client (Anderson, 2003). The concept which was originally used in the context of interactions between different racial or ethnic groups has been expanded by some to be applicable in any clinical interaction between individuals with different worldviews (NAHO, 2008). The concept of cultural safety is predicated on the understanding that a caregiver's own culture, and assumptions that follow, impact the manner in which a clinical encounter is played out and therefore impacts the patient's care. The burden of cultural adaptation that results when intercultural interactions occur, should be relieved from the patient whenever possible (Paasche-Orlow, 2004).

Cultural safety is integral to clinical safety: it is about minimizing risk and providing a safe healing environment (Bunker, 2001). Cultural safety educators aim to impart the understanding that past and present socio-political processes are intrinsically connected to contemporary health and social issues (Smye, 2002; Browne, 2002).



Knowledge of cultural differences is the first step. Caregivers need to also understand the ongoing impact of intergenerational trauma and continued injustices (NAHO, 2008). Skills gained from this understanding are transferable to many cultures. It helps to prevent oversimplification and stereotyping that may occur with earlier trends in cultural competency education that focused on the differences between cultures (Bischoff, 2003; NAHO, 2008). Cultural safety educators instead focus on the differences between how various cultures are treated (Paasche-Orlow, 2004). At the level of the individual, cultural competence focuses on patient-centered care which improves care regardless of nationality, culture, age, gender or religious beliefs (Anderson 2002; NAHO 2008).

A true understanding of the imbalances in a caregiver-patient dynamic requires that the caregiver engage in a process of self-reflection in which one's own culture and assumptions are recognized (NAHO, 2008; Papps, 1996). This attitude of "cultural humility" entails an enduring commitment to self-evaluation and self-critique (Bischoff, 2003). A culturally safe environment develops from an individual and institutional philosophy of empowerment, individuality and choice (Bunker, 2001). Patient empowerment arises from practices that increase access to information and increase individuals' decision making power (NAHO, 2008). The term "health literacy" refers to an individual's ability to use the health care system appropriately and maintain a healthy lifestyle, which is connected to health outcomes (Bischoff, 2003).

Assessing Cultural Safety and Cultural Competency

Migrant Friendly Hospitals, a initiative which aims to improve healthcare delivered to migrants and minorities in Europe, suggests approaching cultural safety as a measure of quality by including cultural issues in all quality monitoring (Bischoff, 2003). Bunker recommends that caregivers be assessed on both practical technical skills and on aspects of attitude and behaviour. Buetow (2004), in his discussion integrating Māori healing with western medicine, stresses the need to use both frameworks to define quality improvement. Since quality improvement develops out of the moral values embedded within an institution it should reflect the moral values of the people it represents. The result is a distinct, hybrid system of quality improvement specific to that institution (Buetow, 2004). The literature on interpreter/translator competencies has expanded to include defined competencies, articulation of standards of practice and accepted codes of ethics (Diversity Rx, 2003; American Medical Interpreters Translators Association,

2003; American Translators Association, 2004; International medical Interpreters Association, 2007). In the U.S.A., since 2001 federal funding to healthcare providers is premised on conformity to National Standards for Culturally and Linguistically Appropriate Services in Health Care (U.S. Department of Health and Human Services, Office of Minority Health, 2001). Assessing competency relative to these standards has generated many proponents and approaches (Salimbene, 2002; U.S. Department of Health Human Services, Health resources and Services Administration, 2002; Agency for Healthcare Research and Quality, 2003).

Traditional Healing Practices - Canadian Context

Canadian policy makers are increasingly recognizing traditional healing practices as valuable and appropriate. Despite landmark policy developments such as the 2007 introduction of *Eating Well with Canada's Food Guide - First Nations, Inuit and Métis* (Health Canada, 2007), or the exemption of Ontario's Aboriginal healers and midwives from Regulated Health Professions Act (Regulated Health Professionals Act, 1991), there still exist legal and policy challenges that remain undefined (WalDRAM, 2005).

The Ontario Aboriginal Healing and Wellness Strategy (AHWS) published guidelines for implementing traditional healing programs (AHWS, 2002). It recommends that each organization develop their own program guidelines that respect local healing practices. Through open and honest dialogue the following should be established:

- Appropriate and respectful ways of accessing a traditional healer (this is often from a process of community validation based on reputation of the healer).
- The appropriate offerings and/or payment for the healer (contacting the healer's home community may be helpful).
- Storage and handling of medicine.
- Protocols for dealing with inappropriate behaviour and practices.
- The roles and responsibilities of all people involved in the patients care.

Patient and Client Supports - Interpreter Services

One of the more urgent and immediate interventions to enhance cultural safety is with improved communication through interpreter services. Andrus' study of patients needing interpreter services (n=4 161) found that 75 per cent of those who needed and received an interpreter



described the facility as “open” compared to 45 per cent of those who needed but did not use an interpreter (Andrulis, 2002). Kaufert (1999), O’Neil (1988) and Smylie (2001) describe the disadvantage of using family member interpreters as conflicting values may lead family members to alter the doctor’s message in order to tell the patient what they believe the patient should hear (Kaufert, 1999; O’Neil, 1988; Smylie, 2001).

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Patient and Client Supports - Cultural Translation

The role of the interpreter in many qualitative studies has been documented as a cultural broker or cultural translator (Kaufert, 1999; Smylie 2001; O’Neil, 1988). An examination of the role of the medical interpreters in two Winnipeg hospitals revealed that interpreters mediated potential conflicts, as well as connected patients with traditional healers. In this function they were acting as medical educators and medical advocates: unofficially, bridging the divide between western medicine and tradition healing systems (Kaufert, 1999; Smylie, 2001). The Whitehorse General Hospital builds on the concept of patient empowerment and advocacy by employing liaison workers (Aboriginal Nurse Association, 2005).

PROGRAM DEVELOPMENT

1. Program Design at *Meno Ya Win*

SLMHC was founded as a result of the Sioux Lookout Four Party Hospital Services Agreement which was signed in 1997 by Canada, Ontario, Nishnawbe-Aski Nation, and the Town of Sioux Lookout. The agreement underlines the need for culturally responsive programming in almost every section from the preamble through foundational philosophies and principles to operational and capital funding, planning, service definitions, and special requirements and exemptions.

SLMHC further documented the need for this program in several other documents including:

- *Bi maa dizi win and Meno Ya Win: A Study of Development of Traditional Approaches to Health Care at Sioux Lookout Meno-Ya-Win Health Centre* (April, 2005).

- SLMHC Population and Demographics Study (March, 2005).
- Draft Traditional Medicine Program Proposal (October 2004).
- A Sioux Lookout Meno-Ya-Win Health Centre Backgrounder: First Nations Services (July, 2004).
- Cultural Requirements Report (July, 2004).
- A Personal Journey to Health Care: Whitefish Bay to Sioux Lookout (Fall 2003).
- SLMHC Functional Program, and other working documents.

The *Bi maa dizi win* and *Meno Ya Win* study on the proposed integration of traditional healing and medicine was conducted in 2004/2005. The project team of the SLMHC consisted of eight members, most of whom were Aboriginal and fluent in one of the native languages. The study emerged in the context of amalgamation between a provincial and federal hospital in Sioux Lookout; and a subsequent interest and commitment to utilizing traditional means in health care for First Nations people. The research questions how integration should be carried out and who should be involved. A variety of methods were used.

The views of First Nations community members were explored through: patient surveys; four separate community consultations with 50 Elders from different communities in the service area; and consultations with First Nations chiefs and political and spiritual leaders. The practices of other organizations that provide culturally appropriate care were explored by site visits to 16 organizations in other jurisdictions across Canada. The site visits included interviews with key informants and documentation of demographics, funding, protocols, governance, successes, and challenges.

Results were member-checked with further Elders’ consultations prior to recommendations and program proposals going to the SLMHC Board and government levels for review and approval.

The four main areas of importance that emerged from the consultations with Elders were: language, comfort, escorts and spirituality.

Language: Discussions around language identified that interpreters in all three Aboriginal languages should be available 24 hours, transportation personnel should be fluent in one of the languages, and the pursuit of health careers should be promoted to Aboriginal youth.

Comfort: Access to traditional foods, the serving of foods without spices, and the introduction of cultural activities into the hospital are factors relating to comfort.



Escorts: Respondents recommended that escorting should be a paid job involving training and certification in CPR and First Aid, and that escort policies be developed.

Spirituality: Respondents identified the need for spiritual healing to be respected and for traditional healers to be given the same recognition as a pastor. The ability to choose between diverse practices and the availability of both traditional healing and Christian materials should exist in the hospital.

Respondents also recommended the formation of an Elders Council made up of Elders from the communities who are fluent in English and the native language. The Elders Council would inform the development of the traditional medicine and healing program.

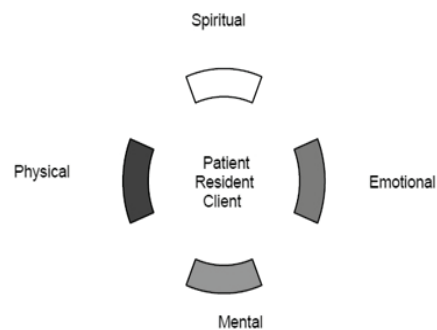
The study further documented that 90 per cent of our Anishinabe patients would use one or more components of the traditional healing, medicines, foods, and services (THMFS) program once available.

The above results from the *Bii maa di zi win* study have informed program development and implementation which is described below, including the now functioning Elders Council.

2. Program Context

The THMFS program was developed to be a core aspect of all SLMHC clinical services. This means that the program is being fully integrated as an element of virtually all clinical programs, not as a separate, stand-alone program. It conforms to the principles of *integrative medicine* and is based on teachings and practices unique to the Anishinabe people of our area. As it develops and matures, the THMFS program will provide a real set of choices: patients, residents, and clients and their caregivers will be able to choose to access the services available through the THMFS program as an adjunct or alternative to other conventional clinical services and supports. The program will become an equal partner to modern (or contemporary) approaches to healing.

Our very name, *Meno-Ya-Win*, is the Oji-Cree word that represents the English terms health, wellness and well-being. It denotes a wholeness of our physical, emotional, mental, and spiritual aspects. The *medicine wheel* is based in part on incorporating these aspects of our being into all healing processes. The THMFS program adds key programming that brings into play *Andaw' Iwe Win* (healing approaches and practices based on this wholeness) and not just *Kee ge win* (the healing of a wound or injury, or care-giving in this physical sense of healing).



The program is informed by and incorporates principles, approaches and practices based on these and other traditional *teachings*. The program is particularly respectful of the sense of *community* and *family* that underpin Anishinabe society.

The THMFS program is developing and operates in the political and social context of Aboriginal and northern health services:

- The importance of treaty rights to health and health services.
- The growing responsibility of First Nations through transfer agreements to provide their own health services.
- The developed continuum of services painstakingly built by the First Nations and the First Nations and Inuit Health Branch of Health Canada.
- The partnerships developed with stakeholder and provider organizations to ensure fewer gaps in service and better local responses to health needs and health status issues.
- The shift to bring services closer to home.
- Provincial policy initiatives determining program priorities and the health transformation agenda.

3. Program Objectives

The THMFS program is intended to:

- Provide a welcoming, supportive, familiar environment for patients, residents, and clients.
- Embed a culturally appropriate set of services and supports.
- Reduce patient, resident and client difficulties in accessing and using SLMHC services to best advantage.
- Provide healing practices, including ceremonies, specific to the Anishnabe context.
- Promote healing and healthy practices.



- Reduce required lengths and frequency of hospitalization and “expatriate” service requirements.
- Provide appropriate choices in healing approach, medications and foods.
- Build a solid foundation for benchmark performance.
- Ensure enhanced levels of organizational, work unit and individual cultural competency.
- Enhance cultural congruency² of the organization.
- Integrate cross-cultural patient safety issues and understanding into the organizational culture of safety and associated practices.

4. Cross-Cultural Patient Safety

The totality of the THMFS program is intended to respond to cross cultural patient safety issues. Our search for a standard of practice in this area took us well beyond the apparent focuses of the Canadian Patient Safety Institute and Canadian Council on Health Services Accreditation in raising patient safety into the limelight. The result of our efforts is the definition of a set of cultural factors which expand the analytical framework for all safety-related programming.

Cross cultural patient safety (CCPS) occurs through “culturally competent” practice and effective delivery of health care services across barriers to understanding; and by overcoming cultural obstacles to implementing prescribed remedial or supportive actions.

The primary frame of reference for CCPS has been the area of linguistic diversity but there are several other important cross-cultural risk factors.

4.1. **Linguistic barriers:** the potential for misunderstanding descriptions of presenting symptoms and history of the client and/or the prescribed course of diagnostic or therapeutic intervention. E.g. a traditional language may have no contemporary vocabulary hence no word or phrase that can be used to communicate an essential idea.

4.2. **Cultural barriers:** the potential for misunderstanding the cultural context of the presenting pathology and/or the ability to successfully implement a prescribed course of action in the face of contradictory world views, perspectives, value sets, norms and mores. E.g. even if the words are understood, compliance may not occur because of differences in custom with the mainstream, or provider population.

4.3. **Practice barriers:** conventional services or practices contrasted with traditional practices specific to the culture(s) in question. E.g. contraindications in the use of manufactured pharmaceuticals concurrent with traditional medicines.

4.4. **Context or structural barriers:** the potential for misunderstanding or mishap due to cultural habitats and (lack of) knowledge associated with them. E.g. the differences in community infrastructure and differences in accessing services and support in urban, rural or remote settings.

4.5. **Systemic barriers:** disconnects between mainstream systems and specific population providers including: territoriality, overlaps, gaps, policy differences, differing approaches, health status, etc. Examples often relate to access and availability.

4.6. **Genetics:** failure to know of or take into account inherent issues in a population. E.g. genetic predisposition to diabetes.

4.7. **Racism/discrimination:** manifestations of bigotry, prejudice or intolerance that result in the differential provision of services or care.

4.8. **Power, history and politicization of health:** spotlights individual issues which risk disrupting energy and resources from other priorities, often associated with ties to treaty rights to health, or racial discrimination as an underlying issue – relates to historical issues and grievances, failure to consult and/or power/control issues.

Failure to identify and respond to patient safety needs beyond medical errors, infection control and adverse events leaves our organizations and patients at very serious risk of harmful outcomes.

These issues must be addressed in order to meet the CCHSA ROPs related to creating a culture of safety and, particularly, to undertake any well-designed failure modes and effects analysis (FMEA) to prevent risks from actualizing in a multi-ethnic or cross-cultural setting. This entails most Canadian health services, whether Aboriginal serving or not, because of the growing diversity of our population.

Ultimately, CCPS is at the desirable end of a continuum that moves from cultural awareness to cultural sensitivity, from sensitivity to responsiveness, responsiveness

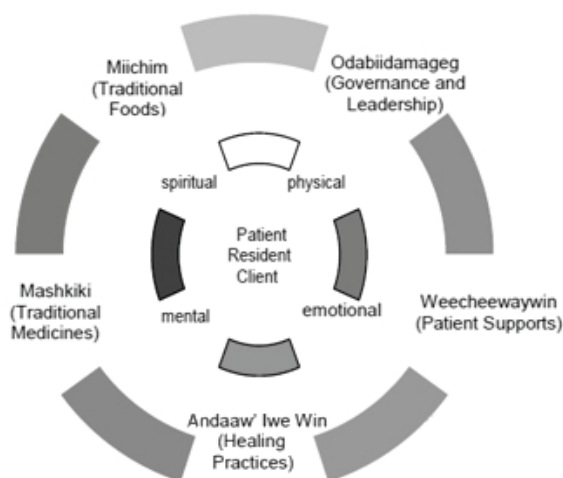


to appropriateness, then cultural competence, and finally cultural safety.

In conclusion, CCPS encompasses a broader set of constructs than conventional patient safety theory and practice. It is rooted in difference and diversity, and is based on awareness, understanding, acceptance, respect, and empowerment of individuals, communities and populations within their own cultural context.

5. THMFS Program Components

The SLMHC Traditional Healing, Medicines, Foods and Supports (THMFS) program includes five core components that echo the foundational philosophy of the program.



Once developed to a point of maturity and fully integrated into our organization, these core components and their foundational philosophy will overlay all other SLMHC patient, resident and client programs and services.

They will provide SLMHC patients, residents and clients with an important range of personal options and the ability to exercise choices in the care that they receive. As each of the elements of these program components is normalized, they will potentially serve as benchmark practices for other First Nations serving hospitals and health centers in Ontario and elsewhere.

The program elements as developed to date are as follows:

1. Odabiidamageg (governance and leadership):

1.1 Board of Directors:

SLMHC is governed by a board of 15 directors appointed on a “proportional representation” basis: 2/3 Anishinabe, 1/3 non-native. The Board also includes two physician representatives and an Elder/healer.

Significant board characteristics are identified below:

- Board appointments are representational, and are not specifically “skill-based.” Appointments are made by the Board after consultation with First Nations or sponsoring organizations.
- The Board operates on a “blended model” versus a “governance model” or “management model” borrowing characteristics typical of both “Chief and Council” and conventional “hospital board” constructs.
- The Board operates successfully as an “integrated” board versus the nominal representation, liaison, consultative, advisory, constituency, caucus, or similar approaches tried by other organizations across Canada which have a mix of Aboriginal and non-native members (Semple, 2005).

1.2 Elders Council:

SLMHC held four major Elders’ gatherings to support Board and Management leadership efforts between Fall 2003 and Summer 2007. Many visits were made to Elders in other contexts. An eight person Elders Council was formally established in October 2007.

- Respect for Elders, their teachings and their counsel is a fundamental value in our First Nations communities.
- Numerous traditional healing programs were visited during the planning of the THMFS program. Virtually all of them underscored the importance of Elders’ support and involvement to the successful development, implementation, management, and continuity of the programs. The means by which this is accomplished varies, but frequently was based on establishment of an Elders’ council connected to the organization or program.



policies governing the use of traditional medicines will be developed. Consultation with Pharmacy and Therapeutics Committee of Medical staff, the Pharmacy Department, the Aboriginal Pharmacy Association of Canada, and others will be required before major enhancements are added.

5. *Miichim* (traditional foods):

Traditional foods⁶ have only been used on a very limited basis to date. Many of our clients are disadvantaged by the need to make a wholesale change in their eating practices and dietary content. A broad range of traditional foods is being added to the menu selections regularly available to patients and LTC residents. Preparation of these foods will require special handling in some instances. Regional variations and preferences in menu item, cooking style (fried, boiled, baked, roasted, dried, smoked, stewed, etc.) will be provided to the extent possible. Menu development and cooking instruction is being supported by Elders from several communities.

Special occasions will require additional traditional food items to be available.

6. Administrative Supports:

Secretarial and research support will be available to the program governance and leadership as required.

7. Program Supports:

The program is supported by a full-time THMFS Program Coordinator who oversees detailed program development, implementation, operations, and evaluation.

CONCLUSION

Achieving cultural integration institutionally is a challenge. Throughout the previous few years the Sioux Lookout Meno Ya Win Health Centre has proceeded broadly, yet with a focus, honouring both the journey and the destination. The approach has arisen from research and broad community and Elder consultation. This model of care is intended to permeate throughout institutional programming. Patients will have choices to access traditional medicines and services. It is expected that this approach will address multiple access to care barriers, which are

intertwined with the twin legacies of “colonization” and “residential school,” and negatively impact the health of First Nations people. We continuously monitor health outcomes. In coming years, we may need to develop novel evaluation tools, which combine qualitative and quantitative methods, and provide more holistic outcome measures.

The THMFS Program at the Sioux Lookout Meno Ya Win Health Centre relies heavily on an understanding and philosophical foundation which is materially different than Euro-Canadian. This tradition may ultimately prove successful at addressing some of the root causes of the profound health status issues facing First Nations.

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END NOTES

1. *Minoyawin* is an Anishinabe term that connotes health, wellness and well-being – a state of wholeness in the spiritual, mental, emotional, and physical makeup of the person.

2. Culturally congruent care is care that is beneficial and meaningful to the person being cared for, and fits within their needs and realities (Leininger, 1988).

3. SLMHC will ensure that birth, naming and dying practices, vigils, healing circles, smudging, singing and drumming, and other healing lodge ceremonies will be available as facilities permit. Sweat lodge ceremonies will be conducted from temporary facilities pending construction of a permanent sweat lodge facility close to the hospital. Some ceremonies need to be delivered over prolonged periods of time and in a specified location and may not be amenable to SLMHC-based support.

4. The Draft Guidelines for Traditional Healing Programs promulgated February 2002 by the Aboriginal Healing and Wellness Strategy will be followed.

5. In addition to herbal teas, wikenj, sage, tobacco, cedar, sweetgrass, etc. many other traditional medicines will added to those available on site.

6. Common foods will include herbal teas; bannock; a variety of fish; rabbit, moose, caribou, and other wild game; goose, duck and other water fowl; nogaiganny; wild rice; and other common foodstuffs will be available.



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