

**University of Alberta**

**Best Practices:  
Does it mean the same thing in the Aboriginal community as it does in the  
Health Authorities when it comes to diabetes care?**

by

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## **Dedication**

This paper is dedicated to my family.

To my boys Solomon, Jack and Cameron whose inquisitive natures have been a constant source of inspiration to me. Over the course of my degree I have watched them grow and my sense of pride in all that they do shows no bounds. They keep me smiling.

To my dad Irvin who told me never to settle. His belief in me is lifelong and I am forever thankful for this. He saw in me early on what I could not ever have imagined in myself. Thank you dad!

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To my brothers and sisters who always showed their love and support in all my endeavors. They carry my heritage and my history and this makes me proud to be Métis.

Finally, this paper is dedicated to my wife Karen, my high school friend who later became my partner for life. My love for her is so profound that words cannot express how I feel knowing that she has been with me all these years. The bond we share is the one true foundation that has allowed me to be where I am today. I share this paper with you as you are a part of everything I do. I love you!

## **Abstract**

For this study I wanted to know if individuals who worked in health authorities and the Aboriginal community had differing views of the concept of “best practices” in terms of diabetes care and what processes were used to determine this definition.

This paper uses a descriptive qualitative study design using Ethnomethodology as the research method. Semi-structured interview questions followed by a total of three scenarios were given to six respondents. Conversational analysis of the interviews was used to obtain data for the results.

My findings suggest that best practices are perceived as being rooted primarily in western science. All respondents viewed their work from this perspective based on their education and work experience. But best practices also have an Aboriginal cultural perspective that may be overlooked by those in the mainstream health care system resulting in significant policy implications at the local, provincial and national health care levels.

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## Table of Contents

Chapter 1	Introduction/Background .....	<b>1</b>
Chapter 2	Research Objectives.....	<b>4</b>
	Research Questions .....	4
	Review of Literature: Method Used.....	5
	Best Practices Defined .....	6
	Aboriginal Health Best Practices .....	7
Chapter 3	Study Design.....	<b>10</b>
	Ethnomethodology .....	10
	Data Sources .....	11
	Informants .....	12
	Criteria for Selecting Informants .....	12
	Letters of Approval .....	13
	Limitations .....	13
	Analytic Methods .....	14
	Conversational Analysis .....	14
	Ethical Considerations .....	15
	Cultural Ethics and Protocol .....	15
	University Ethics Approval .....	16
	Confidentiality .....	16
Chapter 4	Results/Findings.....	<b>17</b>
	Respondents .....	17
	Questions/Responses .....	18
	Question 1 .....	18
	Western scientific realm .....	19
	Aboriginal community realm .....	22
	Basis for defining Best Practices .....	25
	Question 2 .....	27
	Western scientific realm .....	28
	Aboriginal community realm .....	29
	Question 3 .....	31

Question 4 .....	35
Question 5 and 6 .....	37
Question 7 .....	39
Scenario 1. Part 1 .....	45
Scenario 1. Part 2 .....	46
Scenario 2 .....	47
Scenario 3 .....	49
<b>Chapter 5     Analysis .....</b>	<b>52</b>
Context of Knowledge .....	56
<b>Chapter 6     Conclusions/Policy Recommendations .....</b>	<b>60</b>
Policy Recommendations .....	61
Defining Terms of Reference .....	61
Policy Recommendation .....	61
Develop Community Partnerships Models .....	61
Policy Recommendation .....	62
Teaching of Aboriginal history .....	62
Policy Recommendation .....	62
Policy Recommendation .....	62
<b>References .....</b>	<b>63</b>
<b>Appendix A: Guiding Interview Questions .....</b>	<b>66</b>
<b>Appendix B: Information Sheet .....</b>	<b>71</b>
<b>Appendix C: Consent Form .....</b>	<b>73</b>
<b>Appendix C: List of Symbols .....</b>	<b>74</b>

## Chapter 1: Introduction/Background

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Diabetes in the Aboriginal community is 3 to 5 times the national average (Health Canada, 2003) with some communities having rates as high as 26% (CDA, 2003). Diabetes treatment, prevention and health promotion activities have been established in many parts of Canada with the support of the Aboriginal Diabetes Initiative of the Federal government. Since 1999 both on reserve and off reserve Aboriginal groups have been establishing programs to reduce the risk of getting diabetes or prevent long term complications of diabetes through a variety of prevention and health promotion programs.

The Canadian Diabetes Association calls for specific measures to be taken when addressing diabetes in the Aboriginal community. The clinical aspect of these measures fall within the CDA's Clinical Practice Guidelines that all diabetes management programs follow but they also encourage the development of programs and services that incorporate local Aboriginal traditions and cultures that suit the community's needs. More specifically they recommend that diabetes care for the Aboriginal community should reflect the unique cultures, language and geographic location of the communities being served (CDA, 2003).

Since the release of the Final Report to the Royal Commission on Aboriginal Peoples (RCAP) in 1996 there has been a great push to establishing health care services and resources to better meet the unique needs of the Aboriginal communities. This push is not only intended for the providers of health service delivery systems such as the provincial or federal health sectors but also for Aboriginal communities that are undertaking their own control of health services.

What is significant about calls for the health care system to address Aboriginal health issues is the need to ensure that services are culturally appropriate and reflect the needs of the individual community or nation whether it be First Nations, Métis or Inuit. The RCAP report even goes so far as to recommend the establishment of healing lodges that would provide holistic health services under the control of the Aboriginal community.

The federal, provincial and Aboriginal *Blueprint on Aboriginal Health*, developed in 2004, called for the recognition and integration of traditional forms of knowledge to compliment the mainstream health care system. This includes the introduction to traditional Aboriginal forms of health care practices (Federal, p. 5). It also recommends that there be "identifying, sharing and implementing [of] best practices that take a wholistic approach" for programs and services directed at the Aboriginal community (Federal, p. 6).

But the question remains, what are the 'best practices'? Who identifies the practice as being the best? The *Blueprint* recommends sharing the knowledge of best practices but does not indicate the basis for which this knowledge is based. It

also recommends introducing traditional Aboriginal forms of health care practices, but are these recognized as being best practices? If so, by both parties? (i.e., Aboriginal communities and the mainstream health care system).

There appears to be an implicit acknowledgement that each side understands what the other side means when it comes to the term best practices. But the concern is that this may not be the case. Best practices may be viewed by the provincial and federal governments as being rooted in western science and that traditional Aboriginal health practices will be there to only augment or support western based best practices. Whereas the Aboriginal community may recognize the term as belonging to western medicine but may also use it to include traditional Aboriginal wellness as well.

Is the term best practices purely seen as a western concept embedded only in the realm of health care services? Or does it include traditional Aboriginal health care practices as well? And how does either party view it?

The question then is: does each party follow what they believe to be best practices when providing health care needs for the Aboriginal community? How do the different parties define success in terms of best practices and what process is used to establish this criteria? When it comes to understanding what evidence means in terms of establishing and identifying a best practice there needs to be an understanding of the meaning behind the process used to establish the evidence. Does it mean the same thing for both the Aboriginal community and the health authorities? Does the Aboriginal community accept wholly or in part the health authorities' definition of a best practice and the evidence used to establish it? Does the same follow from the health authorities' perspective? If not, does it create problems or barriers? If so, what should be done to rectify this? Is there a need for a common ground or language acceptable by both?

My underlying concern is that there is indeed great disparity between what constitutes a best practice from the Aboriginal community and the health authorities. Knowledge is the significant factor here when it comes to understanding best practices. It is the knowledge of understanding the processes that are used to establish what qualifies as a best practice. What is the basis for a best practice from within the Aboriginal community and what is the basis from within the health authorities?

Both parties need to understand what each is bringing to the table in terms of their respective criteria for a recognized best practice, hence their knowledge of what is best. The question is whose knowledge is being recognized: the health authorities' or the Aboriginal communities', or both? If there is a disparity then whose knowledge on best practices should be transferred and shared as being valid? The question then is whose knowledge on best practices should be shared with whom? And on what basis?

The main concern is that the health authorities may be perceived as not accepting or adopting what the Aboriginal community believes is a best practice because it does not fit the criteria as such set out within the health authority. In this case the knowledge being utilized is from the mainstream health system, not the Aboriginal community. This could be seen as a barrier to providing culturally appropriate health care services for the Aboriginal community, which in turn would continue to contribute to the status quo, which ultimately is seen as contributing to the poor health of the Aboriginal community.

## Chapter 2: Research Objectives

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In order to gain a better understanding of what constitutes success, or a “best practice”, when it comes to Aboriginal diabetes treatment, prevention and health promotion programs and services there needs to be a clear understanding of what the Aboriginal community and the health authorities perceive as being a ‘best practice’. In order to find out there needed to be a critical exploration of the term “best practices” and the processes used to arrive at such a definition from both the Aboriginal community and the health authorities.

For this study I attempted to catch a glimpse of the perspectives of individuals who oversee health programming from within the Aboriginal community and the health authority, in particular where it involves health services to Aboriginal people with diabetes. Workers provide diabetes services under the auspices of their respective organizations. In doing so it is acknowledged that their work flows from their organizations’ guiding mission statements and subsequent goals, policies, and procedures. However, for this study I wished to gain an understanding of how individuals who work in the area of health services and programming perceive such notions as best practices. This type of information will hopefully reflect the structures, guidelines, boundaries and knowledge frameworks used by individuals working within their organizations.

### Research Questions

The following are the research questions that are intended to clarify the issue:

1. Do health authorities and the Aboriginal community have differing views of the concept of “best practices” in terms of diabetes treatment, prevention or health promotion programs geared towards the Aboriginal community? If so do these different views hinder health care services to the Aboriginal community? If so in what ways? What can be done to bridge the gap?
2. What processes are used by the health authorities and the Aboriginal community to determine what a “best practice” is? What criteria are being used? Whose criteria is it? Is there a disparity between the two processes and criteria? Do these differences hinder health care services to the Aboriginal community? If so, in what way? What can be done to bridge the gap?

Finding the answers to the research questions was carried out in two parts. First, a semi-structured interview question format was utilized. The interviews used open-ended questions to explore respondents’ thoughts on “best practices” in the context of Diabetes care. The intention was this would provide me with an assessment of the individual’s current thoughts on the topic of best practices in their current work-place settings.

Secondly, there were a total of three scenarios presented to interviewees followed by further semi-structured interview questions. The scenarios were intended to elicit responses to hypothetical situations. They were constructed to challenge the respondents thinking about different types of Diabetes services. It was hoped that this would provide me with information on the ways in which the informants make decisions when faced with potential challenges to their current working environment. The purpose behind this type of challenge is discussed in greater detail in the section on ethnomethodology.

Please see Appendix A for a copy of the detailed Guiding Interview Questions and Scenario sample.

### **Review of Literature: Method Used**

The process of acknowledging and adopting “best practices” within the health care system highlights the movement towards establishing valid and reliable standards within the whole health industry (Sandelowski, 2005, p. 1368). Such a movement is intended to create a health system that will result in “more effective treatments...accountability in clinical decision making and the empowerment of both practitioners and patients” (Trinder, 2000, in Sandelowski, 2005, p. 1369). But what are “best practices” and where did they originate? How are they applied to Aboriginal health issues? Are there Aboriginal best practices?

In order to answer these questions a comprehensive literature review was conducted using Medline, PsychINFO, CINAHL and EMBASE databases. The following search terms were used in a variety of combinations: “public health”, “benchmarking”, “best practices”, “evidence-based practices”, “evidence-based medicine”, “promising strategies”, “Aboriginal”, “Métis”, “First Nations”, “Inuit”, “North American Indian”, “Diabetes Mellitus”, “Aboriginal diabetes”, “Aboriginal best practices”, “health promotion”, “health prevention”, “theory”, and “history”.

The initial results found close to 2000 possible articles. Out of this a total of 206 articles were highlighted and chosen for in-depth review based on their potential relevance to the study. These were searched to the point of saturation for information that could specifically define best practices, explain its origins, broadly discuss how best practices pertains to Aboriginal health, and describe and define Aboriginal best practices. In all, 87 articles were reviewed from Medline, 7 from PsychINFO, 21 from CINAHL and 91 from EMBASE.

Excluded articles were ones that focused primarily on specific research questions such as those that discussed the results of clinical trials or interventions that pertained to diabetes treatment. Such articles were not included as they did not add to the broader discussion of best practices as a concept. Other articles excluded were based on age (older than 1998, unless directly related to the origins of the topic), language other than English and the inability for the University of Alberta to obtain such articles.

Grey literature was also searched. Such sources included Federal and Provincial government publications as well as articles and discussion papers published by Aboriginal organizations. Articles reviewed in this section were searched for information that could provide a definition of best practices but also offer some insight in to the concept of best practices as they pertain to Aboriginal health issues.

The final list of articles used for this study was chosen for the following reasons: they gave a clear and workable definition of best practices and its origins and provided information on how best practices relate to Aboriginal health issues.

### **Best Practices Defined**

In order to come to an understanding of the definition of best practices a content analysis of the selected literature was conducted. This is a “systematic, replicable technique for compressing many words or text into fewer content categories” (Stemler, 2001, p. 1). Content analysis of written text can “extrapolate...implicit beliefs and make them visible” (Rothe, 2000, p. 105) and allow for a deeper clarity of the content. I chose articles from a number of categories that included medicine, nursing and public health and health promotion.

The term “best practices” is a broad term that began with the development of “evidence-based medicine” of the early 1990’s. Evidence-based medicine has roots not only in medicine (Haynes, 2002; Sackett, 1996; Ghosh, 2004; Grol, 2003; Downing, 2006), but also nursing (Driever, 2002; Rolfe, 2005; Brown, 2001; Munro, 2004; Ingersoll, 2000), and public health and health promotion (Green, 2001; Nutbeam, 1996; Sandelowski, 2004.). The concept of evidence-based medicine was originally defined in the field of medicine as “the conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual patients” (Sackett, 1996, p. 71).

The first definitions of evidence-based medicine did not include much emphasis on patient or population needs or circumstances but have since been changed to include this. In short, the process used with evidence-based medicine is that individual practitioners would use their clinical expertise and integrate it with the latest systematic research to make treatment decisions for their patients or populations.

In its strictest sense research using the latest randomized clinical trials (RCT’s) is used as the gold standard for evidence (Green, 2001; Driever, 2002; Perleth, 2001; Rolfe, 2005; Ghosh, 2004; Downing, 2006; Haynes, 2002; Sackett, 1996; Sandelowski, 2004 and Grol, 2003). But in its broadest sense evidence can come from such other sources as quality improvement; evaluation data; retrospective chart reviews; and international, national and local standards (Driever, 2002). According to Green such evidence can also be used in health promotion activities to find “ways of engaging the community, ways of assessing resources, ways of

planning programs, and ways of matching needs, resources, and circumstances with appropriate interventions” (p. 8).

In order for the latest evidence-based research to be provided to practitioners, organizations such as the Cochrane Libraries and the Campbell Systematic Reviews have been established. A systematic review is a process whereby authors locate and synthesize scientific research and rate them on their effectiveness based on a predetermined scale. They have been established for quick and easy access over the internet (Green, 2001, p. 4).

Using content analysis as the method in reviewing the literature I have extrapolated four elements from the articles that can be used to define evidence-based medicine: research evidence; the patient’s presenting clinical state and circumstance; the patient’s ability to choose treatment options; and the practitioner’s clinical expertise in combining all elements in order to make a treatment recommendation.

“Best practices” on the other hand is a broader term that is referred to more as an organizational concept. It is “process oriented in achieving improved health outcomes” (Driever, 2002, p. 594, Perleth, et al, 2001, p. 237). Whereas evidence-based medicine is seen as the “foundation” upon which to access knowledge and make treatment decisions, best practices are seen as the “process framework” that guides how evidence is translated into day-to-day practice (Driever, 2002, p. 594; Green, 2001, p. 8). This process could be used to plan the best health interventions for a patient or population.

This perspective would allow for a better way for practitioners and policy makers to understand the needs of a patient or population in order to make appropriate treatment decisions based on their needs (Driever, 2002, 173). This approach would further distinguish the two concepts from each other – evidence-based medicine being clinical research oriented and best practices being organizational and process oriented. In other words, best practices would not only include the four elements of evidence-based medicine described above but would also include such areas as organization system’s policies and quality care systems such as evaluation data (Brown, 2001, p. 2).

### **Aboriginal Health Best Practices**

In light of the identified elements outlined in the definition of best practice from the literature discussed above it was important for me to consider elements that are crucial for addressing Aboriginal health. Considering that the Aboriginal community is a specific population that is faced with unique health challenges it was important to approach such matters from a population health perspective. This type of approach would fall in line with the notion outlined by Driever and Green and look at best practices for the Aboriginal community as being process oriented. It would allow the Aboriginal community to address specific health issues such as diabetes care from a community or communal perspective.

Both the Aboriginal community and the health care system want a system that understands and meets the unique health care needs of the Aboriginal community but also one that works effectively. This is where the concept of “best practices” is so important. The concept of best practices and finding ways to apply it to the health needs of the Aboriginal community is very complex. An example would be that the term in its present form does not explicitly take into consideration a communal approach to health that may include unique cultural viewpoints on wellness. The challenge here is to bring research on treatment for individuals and apply it to a community or a group of people.

It is becoming more clear that programs and services within the health care system must meet certain standards that not only reflect the best available research knowledge of treatments and services but that also display clear levels of effectiveness in their outcomes. Do treatments, programs and services do what they intend to do and are they based on the latest advances in research knowledge? Health systems need to know if they are providing health services in the best possible manner. But what constitutes best: Effectiveness? Efficiency? Efficacy? Patient satisfaction? Appropriateness? etc? Is this what is also meant by best within the Aboriginal community?

What becomes the bottom line in this type of scenario is whether or not there is evidence to support if treatment services and programs being provided are appropriate and effective. Is there sufficient clinical research or properly conducted evaluations to back up such claims? Cost-effectiveness is also very important in this era of cost saving measures in health expenditures, however, the complex nature involved in exploring such measures is not within the scope of this paper.

In order for health programs and services directed at the Aboriginal population to be truly reflective of the community’s unique traditional and cultural needs each program must also be culturally responsive. For example, indicators of community wellness as outlined in the First Nations Regional Health Study (RHS) of 2002 include such factors as traditional language, knowledge of the land, shelter and healing medicines (AFN, 2007, p. 21). The RHS stresses that the concepts of wellness of a First Nations community can only be measured using a First Nations’ knowledge framework and that improved community wellness will occur only with an increase in traditional medicine practices and culturally sensitive healing and knowledge paradigms (AFN, 2007, p. 22). In this type of situation it is crucial therefore to have a clear understanding of what best practices means from both the Aboriginal community and the health care system in order to identify appropriate interventions and measurable successes within treatment programs and services.

Many of the Aboriginal diabetes initiatives established throughout Canada are community-based programs aimed at providing services at the local community

level that reflects and respects the culture. Many Aboriginal health programs established within the health care system attempt to address health and wellness from a traditional Aboriginal holistic perspective often incorporating some form of cultural approaches to wellness. It is important to stress that successes within such programming must not only be recognized from a clinical health care perspective based on criteria set out by the health authority but also recognize the significance of Aboriginal community perspectives of success. It is at this level that clarification is needed when it comes to determining what constitutes a successful program or hence a best practice. Also, from whose perspective is a best practice determined - the health authorities or the Aboriginal communities, or both?

## Chapter 3: Study Design

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### **Ethnomethodology**

This paper followed an exploratory descriptive qualitative study design using Ethnomethodology as the research method. Ethnomethodology is a sociological term developed by Harold Garfinkel in the early 1960's and is used to describe the methods of how people make sense of their world about them. It supports the notion that within society all interactions, whether they take place at home, in the workplace, or in the community, have the potential to become chaotic therefore we establish some sense of social order through the use our personal experiences, recognized patterns, and knowledge of our world around us in order to make sense of these interactions.

Ethnomethodology is “the study of everyday life, the routines and rules people use to go about their everyday business, the norms and values they employ to deal with and relate with other people” (Slattery, 2003, p. 104) and of how we in society “find reason and formulate our actions and behaviors in everyday settings” (Dowling, 2005, p. 826). It is “the study of common-sense knowledge, procedures, circumstances, reasoning and considerations by which...people make sense” (Rothe, 2000, p. 44).

An ethnomethodological viewpoint believes that social order is very sensitive and precarious. Any real or perceived challenge to this social order has the potential to create chaos and uneasiness to individuals experiencing this threat. Our everyday routines that help maintain our sense of social order are very important for us in order to function properly and make sense of our world. It is these routines that allow us to function as a social group at home, at work, or out in the community. The routines are done at a subconscious level and are taken for granted as they are so ingrained in our being.

When faced with a challenge to our sense of order and routine the individual is expected to rely on this subconscious knowledge and use his or her abilities to bring back their own sense of order to create some understanding of the changing circumstances. An example of when this type of threat occurs would be when a person sings loudly on a crowded bus (Slattery, 2003, p. 103) or when someone breaks into a queue (Rothe, 2000, p. 46).

For the ethnomethodologist, it is the study of the persons' behavior when experiencing these types of challenges that is important. Two things are relevant here: the routines and the behavior used when challenged by a break in the routine. This type of research attempts to gain an understanding of these everyday routines and the rules that govern peoples' behaviors, thoughts, and actions. The researcher asks questions in order for the subjects to reflect on thoughts and actions and uses this as their basis for their study (Dowling, 2005; Slattery, 2003). I have chosen this type of approach for this research study.

There are two components to this study. First, I wish to find out how health care managers or program coordinators from the health authorities and the Aboriginal community make sense of their Aboriginal health programming world. How do they go about creating a sense of order to govern their day-to-day tasks that involve Aboriginal health, particularly when it comes to Aboriginal diabetes? This would involve consciously thinking about what is normally left at the subconscious level (how they make decisions and what reasons do they give for these decisions). The first set of open-ended interview questions were used to obtain this information (See Appendix A for Guiding Interview Questions). These first sets of questions do not pose any challenges to the individual's normal routine and will act as an assessment on the participant's current thinking.

For the second part of this study I explored how these individuals make sense of their world when faced with potential challenges to their sense of order. This was intended to demonstrate how the informants define their normal working world when faced with new challenges. Scenarios, followed by more open-ended interview questions, were used to get this information. By using different scenarios the writer hoped to ascertain how these individuals adapt to new challenges to their current working environment.

The scenarios posed were real-world situations that have the potential to challenge the informant's current working environment. They involved specific requests or circumstances that each informant was asked to explore and answer based on their current role within their respective organization. An example of such a scenario is a specific request for a new or unique service from the Aboriginal community that their organization may not presently offer.

Once the scenarios were developed then they were pre-tested. The pre-tests were done with a Registered Dietitian and a Registered Nurse who have experience working in the area of diabetes education with the Aboriginal community. The scenarios were written in such a way that they had a strong possibility of actually occurring in a real work setting. The pre-testing was done to check for realism and relevancy of the scenarios. I wanted to see if the scenes posed would be viewed as being realistic to anyone working in the area of Aboriginal diabetes.

For this research project interviews were conducted with a total of six key informants representing three Aboriginal organizations or communities that provide Aboriginal diabetes programming and three provincial health authorities that provide care for Aboriginal clients with diabetes.

### **Data Sources**

Interviews were recorded using a tape recorder with each key informant and lasted approximately one hour in length. The writer transcribed five of the six interviews and contracted a typist to transcribe the sixth one. Each interview was written verbatim. Text of the interviews was coded (see List of Symbols for

informant interview codes meaning) and categorized into a variety of themes and concepts as per conversational analysis protocol. Each interview was conducted in a private setting at a convenient time and location of the informants choosing.

### **Informants**

Purposive Sampling was used to select each of the six informants. As this type of sampling suggests, informants were chosen based on a certain criteria. Potential informants who did not fit this criterion were rejected. Each of the six informants held the position of, or similar to, a coordinator, manager or director within their respective organizations. This was done in order to ensure that each was able to answer the questions candidly and with authority. It was important that interviewees were able to answer questions freely without the need to defer to a higher authority such as their direct supervisors. The questions posed established a snapshot of the perceptions of individuals in certain positions of authority. They were employed in a health organization or departments whose programs they oversee included one or more of the following: diabetes treatment, prevention or health promotion programs or services that serve Aboriginal clients.

There were a total of six interviews: the Aboriginal community informants included two from First Nations communities and the other from a provincial Aboriginal organization. Of the three health authority informants, there was a mix of urban and rural participants. It was important to obtain the perspective of a variety of Aboriginal communities and health authorities as they represent a variety of factors affecting Aboriginal diabetes programming and services: access to treatment, prevention and health promotion programs, geography, and traditional culture.

### **Criteria for Selecting Informants:**

Considering the nature of this study the following criteria was utilized to select candidates. Because this is exploratory research it was important to investigate a wide variety of perspectives:

1. Informants should bring knowledge of diabetes care in one or more of the following areas: diabetes treatment; diabetes prevention; or health promotion programming.
2. Informants also needed to be able to articulate freely their knowledge of the administrative aspects of their positions as coordinators, managers or directors within their respective organizations.
3. Informants needed to be in a position to speak candidly and freely without deferring to their direct supervisor for authorization to answer specific questions.
4. Informants must be willing to volunteer their time for the study.

The First Nations community informants were identified through a contact I had with the Aboriginal Diabetes Initiative (ADI) Coordinator from the First Nations and Inuit Health Branch, Health Canada, in Edmonton, Alberta. The Aboriginal Diabetes Initiative was established by Health Canada in 1999 as part of their

strategic plan to address Aboriginal health. It is also a direct response to the Final Report to the Royal Commission on Aboriginal People released in 1996.

The ADI provides diabetes prevention and health promotion funding for programs that are community-based in First Nations and Inuit communities. A separate component also offers funding for Métis communities, off-reserve First Nations and Aboriginal urban communities. Each program is designed to encourage traditional Aboriginal practices and methods whenever possible.

I already had a professional connection to the ADI Coordinator and this relationship allowed me to link up with potential candidates to interview based on the above chosen criteria..

Once Aboriginal community informants were selected then health authority informants were chosen. Since it is important to gain insight from individuals who work in the health authorities irrespective of existing Aboriginal Diabetes programming, I identified individuals in both rural and urban health authorities to speak with. Health authority informant connections were made with the assistance of the respective Aboriginal communities in the region.

### **Letters of Approval**

Each informant provided a letter of approval for them to speak on behalf of their organization.

### **Limitations**

The central question to this study asks whether the term best practices means the same thing for the Aboriginal community as it does to the health authorities when it comes to diabetes care. It is acknowledged that conducting six interviews on the topic of best practices with the health authorities and the Aboriginal community may not wholly represent each party's viewpoint on the topic. It is also acknowledged that any definitions or perspectives that come from the representatives of either party may not be anything more than individual thoughts and impressions.

Having three individuals provide very similar answers to the question of what is a best practice may reflect the broader community's perspective but the scope of the study is limited in its ability to be externally valid with its findings. If anything, the results of this study may provide a focal point in which to explore the discussion more in-depth at a later time. A greater exploration of this topic may find a truer reflection of whether or not health authorities and the Aboriginal community's think that best practices mean the same thing.

Another noted limitation to this study is the fact that four of the six respondents were registered nurses. Each spoke very strongly of their professional training in western sciences and have expressed that such training is what they used as a basis for looking at health issues, whether in mainstream health care or Aboriginal

health. This type of scenario provided a limited viewpoint from an Aboriginal community perspective and places a heavy emphasis on the clinical aspect of the term best practices.

The language and terminology of the phrase best practices in itself can also be considered a limitation to the study. The term best practice is rooted in western science and it is a relatively new term within the Aboriginal community. Perhaps a more general term should have been considered. One that would allow each respondent to focus on best approaches for addressing Aboriginal health issues from each party. Then this way there may be a stronger sampling of the perspectives of each respective area, the health authority and the Aboriginal community. This approach may yield a better sampling of what the health authority's see as a best approach for addressing Aboriginal diabetes and what the Aboriginal community would see as their best approach.

Homogeneity of the respondents is another issue that speaks to the limitations of the study. Interviewing six informants representing the Aboriginal community and the health authorities cannot truly represent the whole of each group. There are too many factors to address to come to such a conclusion, such as whether the informants represent urban or rural areas, come from nursing or medicine or are First Nations, Métis or Inuit. In this case the study is too small to reflect the thoughts and perspectives of each of the various communities involved.

### **Analytic Methods**

In order to analyze the data from both parts of the study I utilized conversational analysis.

### **Conversational Analysis**

Conversational analysis is a tool of Ethnomethodology that “focuses on the detailed features of talk and their role in creating and sustaining a sense of social order” (Rothe, 2000, p. 49). It originated in the 1960's through the work of sociologist Harvey Sacks. The use of conversational analysis provides the author an analytical method “that can be used to expose the underlying structural rules that govern how day-to-day activities are composed and organized” (Chatwin, 2004, p. 131).

The interview is the main method used in collecting data for conversational analysis. The interview is considered “a social encounter in which knowledge is constructed” and not just a “pipeline for transmitting knowledge” (Holstein and Gubrium, p. 68 in Dowling, p. 829). Hence, I used conversational analysis of interviews to assess the underlying rules that govern the day-to-day activities of health program managers and diabetes coordinators in the area of Diabetes care.

Conversational analysis is useful in understanding how individuals in these types of settings make sense of their working world. The first set of interview questions were used to provide a glimpse of how these workers are able to make sense of

their environment under normal everyday circumstances. Then secondly, the scenarios and subsequent second set of interview questions were used to demonstrate how these workers managed to maintain a sense of order in their working environments when faced with potential challenges to their everyday working environment.

The scenarios were constructed so that they would require the respondent to think beyond their everyday limits. I wanted to know how they would respond to a potentially real life situation where they would have to answer a question or respond to a query that could possibly become real. The scenarios used in this study challenged the conventional thinking of the informants by incorporating elements of a diabetes awareness activity that included both clinical medicine elements as well as some Aboriginal cultural elements. As the activity could be seen as being realistic the informants would have to think outside of their usual frame of reference but with the authority to respond on behalf of their respective organizations. .

In this way, I attempted to ascertain a clearer description of how individuals who work in the health care field as program managers or coordinators come to a definition of what constitutes a best practice when it comes to Aboriginal diabetes care. I used this to assess the structures, rules and knowledge used by the workers to make such decisions.

### **Ethical Considerations**

#### **Cultural Ethics and Protocol**

Traditional spirituality and the cultural protocols that respect and honor this are often not clearly evident to those outside the Aboriginal community. Therefore it was very important to have an opportunity to open up a dialogue that would show that this would be respected and followed should it be necessary when accessing the individuals from the Aboriginal community. It was important to acknowledge and appreciate traditional cultural protocols and procedures that may have been required when seeking access to individuals from the Aboriginal community.

All efforts were made to ensure that community cultural ethics and protocol were followed according to each Aboriginal community's needs. Each contact within the various Aboriginal communities was asked if such a cultural protocol existed and if so the author would have followed any cultural directions requested by the community. In the end there were no formal traditional protocols that needed to be done.

Also, when requesting interviews with health authorities I inquired as to whether or not there were any formal processes that I needed to follow in order to have the interviews granted. This included letters of support from the informant's direct supervisor or department head or any other such administrator. As a result each informant was able to provide a letter of support from their respective supervisor.

For the purposes of this project I formally presented tobacco as a cultural and spiritual offering to an Elder that is known personally. This Elder did not have any direct links to any of the Aboriginal communities or the informants being interviewed. The purpose of this offering was to ask for cultural and spiritual guidance in order for the research project to be conducted appropriately. This process was also used as a foundation to ensure that all other cultural protocols required by the Aboriginal communities would be met.

### **University Ethics Approval**

Ethics approval was obtained from the University of Alberta's Health Research Ethics Board. Once approval was obtained then formal contacts with the communities and health authorities was made. An information letter was provided outlining the project and expectations for key informants and an informed consent sheet was provided to each participant (see Appendix B and C).

### **Confidentiality**

Confidentiality and protection for personal privacy is extremely important. Interviews were conducted in a closed office space where the conversation could not be overheard. Each informant interview was tape recorded and gave no evidence of physical or personal attributes. Personal names were not utilized during the taping and the subsequent transcriptions. Every effort was made to not include direct quotes or paraphrases within the body of the text that would directly or indirectly identify the informant. The tape recorded interviews were placed into a locked cabinet for safe keeping in the office of the writer's supervising professor (Dr. Laing) at the University of Alberta for a total of five years. Any other written material or correspondence will not have any personal information that will identify the informants.

## Chapter 4: Results/Findings

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In this study I wanted to critically explore the term “best practices” and the processes used to arrive at such a definition from both the Aboriginal community and the health authorities. The research attempted to catch a glimpse of the perspectives of those who oversee health programming from within the Aboriginal community and the health authority, in particular where it involved health services to Aboriginal people with diabetes. The following are the research questions used to gather such information:

1. Do health authorities and the Aboriginal community have differing views of the concept of “best practices” in terms of diabetes treatment, prevention or health promotion programs geared towards the Aboriginal community? If so does this hinder health care services to the Aboriginal community? If so in what ways? What can be done to bridge the gap?
2. What processes are used by the health authorities and the Aboriginal community to determine what a “best practice” is? What criteria are being used? Whose criteria is it? Is there a disparity between the two processes and criteria? Does this hinder health care services to the Aboriginal community? If so, in what way? What can be done to bridge the gap?

Finding the answers to the research questions was done in two parts. First, a semi-structured interview question format was utilized. These were open-ended questions that explored respondents’ thoughts on “best practices” in the context of Diabetes care. The intention was this would provide me with an assessment of the individual’s current thoughts on the topic of best practices in their current work-place settings.

Secondly, there were a total of three scenarios followed by further semi-structured interview questions. The scenarios were intended to elicit responses to hypothetical situations. They were constructed to challenge the respondents thinking about different types of Diabetes services. It was hoped that this would provide me with information on the ways in which the informants made decisions when faced with potential challenges to their current working environment. The purpose behind this type of challenge was discussed in great detail in the section on ethnomethodology.

### **Respondents**

In order to understand some of the answers to the questions asked it was equally important to know about the various respondents. I interviewed three individuals from the Regional Health Authorities (RHA’s) and three from the Aboriginal communities. All the correspondents were female. Of the RHA respondents two were registered nurses (one of them was Aboriginal and the other was non-Aboriginal) and the third non nurse RHA respondent was Aboriginal. The

Aboriginal community respondents had two Aboriginal registered nurses while the third was non-Aboriginal.

Of the respondents working for the regional health authorities all were responsible for overseeing aspects of Aboriginal health programming that would include addressing diabetes care for Aboriginal clients. Two of the programs were not specific to Aboriginal diabetes as a separate program but were part of the overall services to people with diabetes that the health authority provided. The third was a program specifically designed to address Aboriginal diabetes within the health authority. The role of each of these individuals was to provide support and guidance in addressing Aboriginal diabetes issues for the health authority.

Within the Aboriginal community programs, each respondent coordinated programs specifically designed to address diabetes care. These individuals were directly involved in managing community-based services for Aboriginal clients with diabetes ranging from direct clinical care to health promotion. The two registered nurses managed clinical care programs for clients with Diabetes while the other Aboriginal community informant coordinated health promotion programs designed to bring awareness to diabetes prevention.

The two respondents who were not registered nurses (one from the health authority and the other from the Aboriginal community) have been working on behalf of Aboriginal health for a number of years. One is Aboriginal and is involved in advocating the health care needs of the Aboriginal community as part of her role within the health authority. The other is non-Aboriginal and her role is to promote the health of Aboriginal people on behalf of her organization.

All the respondents worked for the Aboriginal community at some point during their careers, either providing direct nursing care or assisting and advocating for health services. All of the nurses were involved in working directly in the First Nations community in the past, some in urban centres and others in rural northern areas. One health authority respondent stated “I’ve always been working with the Aboriginal community...I see [best practices] from that context and that’s my belief system” (RHA3, 83). Another nurse from the Aboriginal community stated her work with First Nations communities allowed her to learn more about “what influences their health” (AC2, 165) from a cultural and holistic perspective.

## **Questions/Responses**

### **Question 1: What do you think best practices means?**

The first question is straight forward. It asks, what do you think best practices means? The responses to this question highlighted the fact that there are individuals who have been trained in western sciences through their nursing education. Many of the responses focused on defining best practices much the same way it is described in the literature. Examples are evidenced-based research, expert advice, and recognized clinical standards of care.

At the same time however, the responses highlight the fact that each of the respondents have either worked with the Aboriginal community in providing direct health services or have worked towards advocating and promoting for better health services. Examples of such responses include community engagement, recognizing cultural needs and relationship building.

As a result of such diverse answers to the question of what best practices mean I have categorized the responses into two sections. The first one I placed answers under the western scientific realm and the other under the Aboriginal community based realm.

### **Western Scientific Realm**

As mentioned previously the concept of the term “best practices” is rooted in western science. The term began with the development of “evidence-based medicine”. It was originally defined as “the conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual patients” (Sackett, 1996, p. 71).

What this means is that practitioners would make treatment decisions based on strong scientific research and integrate it into their practice. Such research would include the latest randomized clinical trials as the gold standard for evidence. But other evidence could also come from such other sources as quality improvement; evaluation data; retrospective chart reviews; and international, national and local standards to name a few.

Most of the responses to this first question identified elements that would fit the formal definition of best practices. There is recognition that finding the best ways to offer health care services does have a scientific base. It is steeped in research that is seen as the evidence to back up clinical standards. These standards are the clinical practice guidelines that identify the latest skills and knowledge used by health care professionals to provide the best health care services.

Under the scientific realm I have categorized the responses to this first question into three sections.

1. Evidence-based research.
2. Clinical Standards.
3. Expert Advice.

The first section, Evidence-based research, describes elements similar to the western scientific definition of best practices described earlier. It includes the notion that best practices must be based on scientific evidence. This includes evidence from research that shows the “best” way to provide health care services as well as statistics that show results. The use of literature searches to find the latest evidence on best practices was stressed as being an important process to utilize.

The second section, Clinical Standards, identifies how the latest best evidence is put into the context of clinical practice, hence best practices. This section emphasizes the professionalism used by the respondents in providing health services. It was important for the respondents to ensure that health care services being provided are using the latest clinical procedures and skills to carry out their duties. Often times this means that such services have already been identified as being a best practice and have been utilized elsewhere in other health authorities or communities.

The third section, Expert Advice, was emphasized to highlight the fact that providing health care services and delivery is very multifaceted and involves many other disciplines. This would include recognizing and utilizing experts in the clinical field such as nurses, dietitians, endocrinologists and health program planners. But the respondents also acknowledged the need to recognize and use cultural expertise such as Elders, Aboriginal community members, or other disciplines with experience working in an Aboriginal cultural setting.

Of the six respondents, one from the Aboriginal community did not describe her definition of best practices as belonging to the Western Scientific realm. All her responses were placed in the Aboriginal Community Based realm. Her discussion on the topic of best practices pertained to her current work in providing health promotion programming to her community from a non-clinical perspective. This is due to the fact she is not a medical clinician by trade and acknowledges that this is not her jurisdiction or the program's mandate. At the same time her responses were mainly focused on the community aspect of her work and not on the specific terminology used to define health promotion and prevention practices.

At the same time, one of the Health Authority respondents clearly identified best practices as being primarily in the western scientific realm relying on evidence-based research, clinical standards, and the advice of experts in the field – doctors, nurses or other disciplines that work in the area of Aboriginal diabetes. This respondent gave a lot of “credence” (RHA2, 249) to the clinical training and experience in experts in the field and in the researchers conducting studies published in respected scientific journals. This respondent did indicate that it is equally important to recognize and seek out cultural experts such as those clinicians who work with the Aboriginal community in providing culturally based diabetes programming.

Out of the remaining respondents each recognized the importance of evidenced-based research to support health care practices and services. Researching the latest literature on a particular program or practice was identified as the appropriate course of action. Such research is used to find “the best practices, or...the best clinical ways to work with patients around a particular condition or disease” (RHA2, 42).

Each emphasized that research is a process that is required before such practices can be fully accepted and adopted as a best practice in the health care field. As one regional health authority respondent stated “if you're looking at a best practice...you need to have something that is evidence-based” (RHA1, 135).

It was stressed by many of the respondents that conducting research to find the latest evidence, or best practices, was the basis in which to provide clinical care. This was especially true of all the nursing respondents but also of the non-nursing regional health authority respondent. It was made quite clear that this type of process is required in order to find the “best ways of providing clinical...care” (RHA2, 39). As one Aboriginal community respondent stated this process is important because she recognizes that “procedures [and] skills needed have been researched” (AC2, 52).

Throughout the discussion it was emphasized that research must be “connected to the clinical practice [and that] it must serve the clinician” (RHA2, 172). An example provided by one of the Aboriginal community respondents was the need to provide the latest skills and procedures for providing wound care to clients with diabetes. “Research signifies to me that...some things have been tried elsewhere and they've worked on a specific group of people” (AC3, 78).

Expertise was stressed by some of the respondents as being as important as evidence-based research and clinical skills. When discussed in this context respondents stressed the need to have a multidisciplinary approach to addressing diabetes care. This allowed for the respondents to seek out those individuals that could better support the needs of the program and the client.

It was highlighted by two of the health authorities and one of the Aboriginal communities that having experts in the field to support Aboriginal health programming was crucial to providing best practices. As one health authority put it “I'm really borrowing other people's expertise” (RHA2, 134) saying that she seeks out help because “I don't have the knowledge myself” (RHA2, 148).

The use of expertise included ensuring that programs had nurses, dietitians, social workers and doctors working as a team. This was stressed by two of the Aboriginal community respondents and two of the RHA's who highlighted their programs as including a multidisciplinary approach with nursing staff along side dietitians and physicians. Even cultural expertise such as elders or community health representatives was sought or acknowledged as being important (RHA2, 61; AC2, 185; RHA3, 182).

One health authority respondent gave a different type of example of how they utilized expertise in their region. She stated that they used a consultation process “with a cross section of people within the RHA” (RHA1, 223) to develop their primary health care model.

### **Aboriginal Community Realm**

While the definition of best practices was viewed by most of the respondents as belonging to the western scientific realm there was also a strong emphasis on the Aboriginal community side of things. Each of the respondents indicated that there needs to be some consideration for recognizing that best practices also has equal significance from an Aboriginal community perspective.

Each respondent stated that from their perspective there are certain processes that need to be taken into consideration when looking at addressing best practices in terms of the Aboriginal community. As each of the respondents have worked for or are currently working for the Aboriginal community addressing Aboriginal health issues there is a special emphasis on the approaches used to do this. While most of the respondents understand the significance of recognizing best practices from a clinical western scientific perspective they also stress the need to identify best practices as being outside the western clinical realm when addressing Aboriginal health issues.

All of the respondents emphasized that best practices are identified in a number of capacities when addressing Aboriginal health. Most agreed that whatever is working best for the Aboriginal community as identified by that community is considered a best practice. But the emphasis here is that such recognition must come directly from the Aboriginal community in identifying their own needs and accepting that they should direct what should be done to address those needs.

At the same time, there was a strong emphasis of recognizing cultural considerations when looking at Aboriginal health. There was a need to understand that there is a best practice in respecting and accepting that there is a different process to addressing Aboriginal diabetes that includes recognizing different concepts of “doing business” (AC1,89). This means that the concept of time and the use of other cultural processes such as relationship building and seeking the advice of Elders and other cultural people are very important.

Under the Aboriginal community realm I have categorized the responses to this question into four sections.

1. What works “best” for the community: as recognized by the community.
2. Community engagement: when addressing health issues and when identifying solutions.
3. Respecting Aboriginal community processes and concepts: such as time and relationship building.
4. Recognizing and utilizing cultural approaches: such as addressing health issues from a holistic perspective and utilizing Elders and other cultural resources.

In its most general description most respondents stated that best practices are whatever health services or programs worked “best” for that community. This included looking at models, frameworks or projects being delivered in Aboriginal

communities and recognizing them as best practices (RHA3, RHA1, AC1). Some suggest that these initiatives should be recognized as best practices even though they are not formally recognized as such (RHA1).

It was suggested that if programs are accepted by the Aboriginal community, are being utilized by the members, and there is recognized growth from a program then it should be considered a best practice. In other words, if the program is working and people are accessing it and it expands or has an increase in usage then it should be considered successful.

As one regional health authority respondent put it “if the community’s accessing it, and continues to access it we’re doing something right...so I would see it as a best practice for that particular area” (RHA3, 111). Another Aboriginal respondent stated a best practice is one that is “Aboriginal community tried” (AC2, 62) and is a service that is of good quality so that it keeps clients coming back to it (AC2, 402). One health authority stated that a best practice is something that is “going to work for the community that you live in” (RHA3, 54). Again, the emphasis here is that many of the respondents believed that if the community recognizes it as a best practice then it should be considered as such.

The only thing that is not clear with this is the criteria used to recognize such a view as being a best practice. Is it Aboriginal community member defined? Aboriginal health employee defined? Regional health authority defined? There was no evidence to suggest any one group.

Another strong component to this section was not just recognizing that best practices are considered to be whatever is working “best” for the Aboriginal community but one that also engages the Aboriginal community. All of the respondents recognize as a best practice the importance of involving the Aboriginal community in identifying the health care needs and solutions for their own community. As one RHA put it they need “to engage the [Aboriginal] community to continue to see what’s needed out there” (RHA3, 125).

An example is having the Aboriginal community involved in developing a health needs assessment (RHA3, 122). All the respondents indicated a need for the Aboriginal community to decide what health issues are important for them to address. This was echoed by one Aboriginal community respondent who stated that addressing Aboriginal health needs have to be inclusive of the Aboriginal community and be community driven (AC1, 284).

An example of the significance of addressing health services or programs from this perspective comes from one of the regional health authority respondents. She stated that health services or programs need to be “community minded, community based, [and have] community engagement” (RHA1, 109). This RHA respondent stated that even if their health authority researched a health program or

service and recognized it as a best practice it could only really be considered as such by the Aboriginal community (RHA1, 93).

Another aspect of community inclusiveness and engagement is also acknowledging and focusing on issues that address the social determinants of health such as poverty, poor housing and substance abuse. This type of approach was strongly stressed by one of the health authorities and two of the Aboriginal community respondents (RHA3, 317; AC2, 96; AC3, 330). Each of them emphasized very strongly the need to understand the historical context of Aboriginal people and how that has affected their current state of health. It was expressed that this is very important to bring to the table when planning health services or programs for the Aboriginal community as “history does help feed into our understanding better” (RHA3, 310).

A unique feature to the responses to the question of what does best practices mean is the idea that this would include an acknowledgement that there are Aboriginal community processes that need to be taken into consideration. This would include the idea that when conducting business with the Aboriginal community time as a concept is viewed differently and that relationship building is very important. These two points are interrelated in that in order to effectively build a working relationship to better address health issues in the Aboriginal community it takes time and effort. More time than is usually allotted from the health authorities to develop and establish programs and services.

As one health authority respondent stated “it's the process of dealing with an issue and using a model to deal with that issue and the process of having that model evolve into... a...recognized best practice” (RHA1, 173) is what is important. This respondent stated that project dollars drive Aboriginal community health initiatives in communities and because of this “I don't know if that gives them enough time to even look at what has come out as a...best practice model” (RHA1, 196).

Having the time to build relationships between the health authorities and the Aboriginal communities was stressed by all the respondents. One of the RHA's stated that she uses her relationship with people from the Aboriginal community when she needs answers to specific questions as “they would know what fits for culture” (RHA2, 61). Another RHA stated that building relationships with the Aboriginal community helps when conducting needs assessments and developing programs that are relevant to the community. She stated that with relationship building they are able to “engage the [Aboriginal] community” to properly assess their needs (RHA3, 125). This same health authority respondent also discussed how she is currently engaging the Aboriginal community to begin discussing appropriate cultural protocols to begin developing their cultural care component (RHA3, 186).

The last section of the Aboriginal community realm is about recognizing Aboriginal culture when it comes to looking at best practices. It is strongly woven throughout the discussions that it is important for anyone involved with working with the Aboriginal community to understand that culture is a part of addressing health issues. One of the Aboriginal community respondents stressed the need for “respecting and honoring the culture and the diversity of their culture” (AC1, 98). She stated that this is important, especially in meetings when first entering into discussions with the Aboriginal community.

What it means in terms of acknowledging the culture is that there is recognition that the Aboriginal community approaches health and wellness matters in a different, but equally effective way than the health authorities. An example of this is when one Aboriginal respondent stated that “we’re looking at the person as a whole, more holistically, as opposed to just...their illness” (RHA3, 141).

Another example is the idea that programs and services need to have advice and guidance from Elders and other cultural support persons (AC1). Another is recognizing that culture plays a part in influencing the health of Aboriginal people (AC2). In fact this respondent stated that “I’m seeing more and more evidence of the culture affecting or having influencing [on] the health of native people” (AC2, 144).

### **Basis for defining Best Practices**

Each respondent was asked to clarify the basis to their definitions of best practices? I wanted to know where their perceptions originated. Why did they respond the way they did? How did they come to their conclusions?

In answer to this question each respondent indicated that they chose their responses based on both their professional experiences in their current roles as well as on their personal experiences in working with the Aboriginal community.

The notion of a formal education and an understanding of the significance of western science and its role in health were highlighted throughout the discussion. Acknowledging this was an important factor in helping the respondents define best practices. It was accepted as fact that western health care and the scientific standards of practice that it produces are integral to the health system.

The first health authority respondent stated that the basis for her definition comes from the fact that she is Aboriginal and she has worked for many years on behalf of her health authority with the Aboriginal community. She recognizes the significance of needing to have western scientifically based standards to health care services. This she accepts as part of her roles and responsibilities within her position with her regional health authority. She stated that she supports the idea that her health authority “should always carry out what we can in a professional, documented, evidence based way” (RHA1, 159).

At the same time this same respondent also emphasized that her experience in working with the Aboriginal community for many years and being a member of that community has strongly influenced her emphasis on best practices being community minded. She acknowledges that it is important for the health authority to understand that there are certain processes and cultural considerations to be addressed when working with the Aboriginal community.

The second health authority respondent outlined that her clinical training in nursing prepared her to work in the health care field from a very strong scientifically based perspective. She is a non-Aboriginal person who had worked in Aboriginal communities for many years. Having credible, evidence-based research was seen as being very important to her in terms of addressing health care services. This belief in the clinical process also extended to the relationships she had with other experts in the clinical field that provided support and guidance to her.

Formal education in the clinical sciences was accepted as a high standard to which she adhered to in terms of trusting information obtained from other experts. Her work experience and education was put in the same light as others who were educated in the sciences and who also have had broad experiences in their respective fields.

The other health authority respondent was an Aboriginal nurse. She stated she was formally educated in sciences and she uses this as her basis to her position within the health authority. But her response to the question of what best practices means was grounded in a strong community context. She defined best practices as being “what’s going to work for the community that you live in” and being able to be “flexible” enough to change (RHA3, 54).

This person based her definition on not only a professional perspective in terms of being formally educated in nursing but very strongly from a personal perspective relying on her experiences of living and working in the Aboriginal community. She stated that “I’ve always been working with the Aboriginal community that I see it [health care] from that context” (RHA3, 83) and that this experience and belief system helped with her definition of best practices.

The Aboriginal community respondents also defined best practices from an evidenced based research perspective. There was an emphasis on clinical skills, standards and professionalism. One respondent stated that her definition of best practices was “the best sample of what we can do, the best project” (AC1, 94). Much of the work done for her Aboriginal community is project funded with a strong emphasis on prevention and health promotion programming as opposed to direct service delivery as the other respondents. She sees her program as being health promotion and not clinical in nature. Based on this experience she sees the success of her projects as being best practices.

The other Aboriginal community respondent is an Aboriginal nurse who placed a lot of emphasis on defining best practices as being “evidenced based” (AC2, 50), especially where it involves learning the latest and most effective procedures or developing the best skill sets. She states that this is important for enhancing the skills and standards of practice for her nursing team especially as it pertains to wound care.

This respondent also stated that she thought research was important because it “signifies to me that...some things have been tried elsewhere and they’ve worked on a specific group of people” (AC2, 78). She stated that it was through her formal training in nursing school that she learned “what has shown to influence health in a scientific...model” (AC2, 122). She trusts this system as something that has been scientifically proven through research.

However, this Aboriginal community respondent also emphasized that her history of working for the Aboriginal community her whole life has also influenced her definition of best practice. She stated that after many years of working with the Aboriginal community she now realizes that there is “more and more evidence of the [Aboriginal] culture affecting or having influence [on] health practices” (AC2, 144). She stated “I’ve learned since then that there’s a whole other realm out there” (AC2, 132).

The third Aboriginal community respondent is also an Aboriginal nurse who is clinically trained in the western scientific realm and has worked with the Aboriginal community for many years. Her definition of best practices is that it is “research based” and includes “quality assurances” (AC3, 60). She states best practice includes providing a top quality program and service that meets all provincial and federal standards, including accreditation standards (AC3, 73).

This person responded that this approach was taken by her due to her role as a nurse and a coordinator of her diabetes program. She stated that her job is to ensure that she is providing a service that is of very high quality. This means meeting standards set by western science and recognized both provincially and federally. She stated that she needs to make sure that the program she is responsible for is professional and uses “top standard protocols” (AC3, 84). She uses this approach because “this is what’s recognized” (AC3, 92) as being a high standard program in the western scientific realm of health care.

**Question 2: How do your diabetes programs fit your definition of best practices?**

This question was asked in order to find consistencies with the answers to the first question. I have divided the responses into two categories: the western scientific realm and the Aboriginal community focused realm.

### **Western Scientific Realm**

In answer to this question three of the health authorities and two of the Aboriginal community respondents stated that their diabetes programs or services did fit into their western scientific definition of best practices. Each of these respondents stated that the programs that are offered within their RHA or Aboriginal community meet this criterion as recognized within western medicine.

The respondents emphasized the notion that best practices were based on evidence backed up through research, maintained clinical standards and professionalism and made use of the expertise of others.

The health authorities recognized the need to establish a focus on Aboriginal health issues and diabetes was considered a top priority. Each health authority has established programming that is considered to be based on the best and most up-to-date standards of practice. The concepts within the programs are recognized as best practices by the western health care system and are used elsewhere.

The three health authorities have diabetes programs that fall under the umbrella of the programs and services that address chronic disease management. Each provides care to diabetes clients using the latest clinical standards of practice set out by their respective health authorities as well as the Canadian Diabetes Association. Each program is based on scientific research, uses standards that enhance skills, are professional in nature and utilize experts in the field of diabetes management.

One health authority outlined that diabetes is part of the region's Chronic Disease program and stated that "any service that we provide will incorporate and be inclusive of the Aboriginal population" (RHA1, 237). Another health authority stated "there is no doubt the regional diabetes program is probably providing excellent best practices" (RHA2, 483). The diabetes program of this region is a part of a program service entitled Primary Care. This respondent stated very strongly that best practices to her meant that it is evidence based, improved skill sets of the clinician and utilized the resources of experts.

The last health authority also says their diabetes program fits into their Chronic Disease Model framework. In fact this program is built on the basis of another community-based diabetes program that was used elsewhere on another select population. This approach was considered a logical step as research had already been done on this type of model. Her definition of best practices included strong support for evidence based research and expert advice.

The two Aboriginal community respondents stated that their programs also fit their definition of best practices. They fall into the categories of evidence based research, clinical standards and provides for procedures or skill enhancements. One also stated that they also rely on expert advice and another strongly emphasized professionalism.

One of the Aboriginal community respondents stated that their program uses professional standards in clinical care. She stressed their use of the Canadian Diabetes Association, Clinical Practice Guidelines as “best practice” standards for their nursing care (AC2, 206). They also recognize that their nurses and dietitian are professionally trained experts and are knowledgeable in the latest standards of care for working with their diabetes population.

The other Aboriginal community respondent stressed the recognition that their program utilizes the knowledge of the latest “tools” (AC3, 126) used to treat and prevent diabetes and its complications. These tools are seen as standards that are recognized provincially and federally by each level of government as well as by the Canadian Diabetes Association, Clinical Practice Guidelines.

### **Aboriginal community realm**

All the respondents in this category recognized that a best practice can be defined as something that works “best” for their community. The responses focused heavily on the idea that programs and services are only considered a best practice if they allow such a definition to come from the Aboriginal community. One Aboriginal community respondent summed it up when she stated that she thinks her program fits her definition of best practices because it means “being inclusive of the community and then...being fluid enough to go with whatever works in the community” (AC1, 258).

All respondents except for one Aboriginal community specifically stated that a best practice is recognized when the health needs of the community are identified by the community. Community engagement was seen as being crucial for addressing Aboriginal health issues. One health authority stated that it is expected that they would seek the help of the Aboriginal community to find out its needs as part of their established relationship (RHA1, 242). Another also stated that they are working from a successful model to help them identify the needs for the “development of an Aboriginal chronic disease management program” (RHA3, 225). They already have done focus groups and a literature search and currently reviewing the environmental scan that was done to search for gaps in services.

Another aspect of the process of community engagement seen by the respondents was recognizing if programs or services were accepted and utilized by the community and if the program has shown growth. One health authority and two Aboriginal communities emphasized this as important as it pertains to their respective programs and services.

Relationship building and recognizing community processes was also stressed by most of the respondents. All have stated that they believed that their programs have established good relationships with the Aboriginal community, enough to recognize this as a best practice. The three health authorities stressed that they have good working histories with the Aboriginal community and will continue to

do so when addressing diabetes through such programs as chronic disease managed care or primary care programs. One emphasized that “any service that we provide will incorporate and be inclusive of the Aboriginal population” (RHA1, 237).

The Aboriginal community respondents echoed similar sentiments when it came to acknowledging that their programs fit their definition of best practices. Relationship building was a key concept when looking at health and wellness for the Aboriginal community. One stated that their program works because they are inclusive of the community (AC2, 258).

One Aboriginal community respondent expressed how their program has developed such a good relationship with the Aboriginal community that it acknowledges and supports the significance that culture plays in a person’s concept of wellness. She stated that the community she works at encourages members with diabetes to participate in the Sundance ceremony. Elders will allow people with diabetes to take breaks for nutrition if necessary and will encourage them to take care of themselves during the ceremony. She stated that “they don’t exclude them from sun dancing but they make that allowance if they’re not feeling well to complete that they can leave and not feel bad about it” (AC2, 255). She stated this type of approach really “stems from the community more so than from the program” (AC2, 276) but acknowledges that there is mutual respect between each other.

The two last categories significant to the Aboriginal community realm is the idea that best practices are acknowledged if there is recognition of cultural approaches to wellness, that it is holistic, and that Elders and other community cultural people are being accessed.

Two health authorities and two Aboriginal community respondents identified the use of Elders and cultural approaches as being significant to their programming. One health authority acknowledged that their health authority also has a diabetes program that is unique as it focuses specifically on the Aboriginal population and uses different teaching methods that are culturally based (RHA2).

The other health authority has already begun searching out the support of Elders in the community to guide the development of their program. They want to ensure that the cultural component to their diabetes program is culturally appropriate and is accepted by the Elders of the community (RHA3).

One Aboriginal community respondent stated that it is important when working with the Aboriginal community to “respect the culture [and] which community it comes from” (AC1, 337). The other Aboriginal community recognized culture as being important to the health of the Aboriginal population. She stated that she knows that culture is a health determinant that needs to be addressed and given the same emphasis as the other health determinants that affect the health of Aboriginal people (AC2).

### **Question 3: What do you think best practice means in the Aboriginal community?**

This question elicited a number of responses that in a general sense mirrored many of the answers the respondents had to the first questions. I have categorized the responses to this question into four sections.

1. Unfamiliarity to the term best practices.
2. Community acceptance and engagement; needs assessments; and addressing social determinants to health.
3. Cultural concepts: holistic health, relationship building.
4. Clinical western definition of best practices

When asked this question five of the six respondents stated strongly that they believe that the Aboriginal community does not know of or is unaware of the term best practices. “I think it’s relatively a new term to the Aboriginal population” (RHA1, 82) is the way one regional health authority respondent put it. But this respondent also said that she thinks that “they do have some best practice models in place” (RHA1, 286) it is just that the term is not used that much.

One Aboriginal community respondent believes that members of the Aboriginal community do not know the term because it is mainly a scientifically based term. She said that she understands the term because she is from a nursing profession and understands what best practices is referring to (AC2, 292).

This sentiment was echoed by one of the RHA’s when she said “I don’t know if they know that word, I think it’s more of a clinician thing” (RHA2, 599). This is based on her experience with working with the Aboriginal community on behalf of her health authority. She stated that when the Aboriginal health professionals are talking about best practices to her “what I get from them is they want...that clinical expertise” (RHA2, 600). She said that they see best practices as “being connected to western medicine” (RHA2, 610).

One Aboriginal community respondent said that she believes members of the Aboriginal community see best practices as being either good services or better services. She stated that members “don’t see best practices as we would as professionals” but instead see it as services “on or off reserve” (AC3, 184). She stated that some see health services as being better off the reserve. So even though they may not understand the term best practices there is an appreciation that the Aboriginal community sees health services as belonging to a certain standard of care, which for some members may appear better off reserve.

This respondent emphasized that the reason for this type of value attached to the standard of care is that many of the Aboriginal communities in her region may not have “full diabetes enhanced programs” (AC3, 198) and are unable to offer best practices clinically due to lack of resources and proper infrastructure. She counts

her program lucky to be able to offer a fully enhanced diabetes program but is aware that such services are unavailable to many other First Nations communities.

The respondents emphasized that even though the Aboriginal community may not be aware of the term best practices in the clinical sense or understand it as much as they do it does not mean that the Aboriginal community does not believe they have best practices or health and wellness practices that they consider best. It just means that the term in its formal sense is not used widely by the community.

Another category for this question falls under the concept of community acceptance and engagement. Most of the respondents stated that they believe a best practice is when the Aboriginal community is involved in deciding what is working best for their communities. It would be up to the Aboriginal community to recognize what a best practice is when it comes to addressing health issues for their population. One regional health authority stated that the Aboriginal community would “look at their community first...and decide what should be incorporated” (RHA1, 269). This health authority respondent stated that the Aboriginal communities she works with use the term model more than best practices but states that “they do have some best practice models in place” (RHA1, 287).

One Aboriginal community respondent stated that a best practice is something that is shown to be successful in “a health project that was started and finished and had some good results” (AC1, 450). A health authority respondent pushed it even further stating that it is important to be inclusive of the Aboriginal community to identify needs and solutions but it is also equally important to address the social determinants of health. She stated that understanding the current issues facing the Aboriginal community is part of “strategizing to create a best practice” (RHA3, 300). She says that understanding Aboriginal history allows the health authorities to see the individual more as a whole person (RHA3, 310). This perspective on the social determinants to health was also supported by one of the Aboriginal community respondents (AC2, 95).

Aboriginal cultural concepts was also a category that fit into the respondents perception of what the Aboriginal community may perceive as being a best practice. Five of the six respondents spoke very clearly that they believed that the Aboriginal community includes cultural processes into their definition of best practices. These can range from looking at health issues from a communal, population perspective to addressing health from a holistic concept to utilizing Elders to relationship building.

The concept of community inclusiveness and being a part of the process of addressing Aboriginal health issues was identified by one regional health authority respondent as being a cultural component (RHA1, 335). Being community minded and focused is considered to be a cultural process that needs to be taken into consideration by the health authority when addressing Aboriginal

health. Placing a strong emphasis on a health issue that the health authority might see as important, such as best practices in FASD for example, may not be what the community decides is important (RHA1, 268). This respondent stated that allowing the community to decide what is important is what the Aboriginal community would see as a best practice in a cultural sense.

One health authority respondent believes strongly that the Aboriginal community defines best practices as belonging mainly to the western scientific realm. She states that this is the impression she gets from the Aboriginal community health professionals that she works with. But she did indicate that best practices could also be seen in a cultural context by drawing in traditional Aboriginal components to health (RHA3, 607). She indicated that she would encourage a stronger focus on traditional meals of “fish and, game and berries and gardens and things that people used to do to maintain their diet” (RHA2, 75) to assist in treating individuals with diabetes. But in direct answer to the question, she stressed that the Aboriginal community would most likely define best practices purely from a clinical perspective.

Community engagement and inclusiveness is an important aspect to developing relationships with the Aboriginal community. This in turn leads to the ability for the health authority to begin to look at addressing Aboriginal health from a cultural perspective that would include a holistic view of health and the use of Elders and other cultural resource people to support initiatives.

One Aboriginal community respondent stated that through her experience she believes that the Aboriginal community looks at things in a holistic way. In order for the health system to be able to appreciate this relationship building must be established. “I just find that the trust and relationship building are really critical” (AC1, 566). This relationship is needed before any negotiations related to health are done with the Aboriginal community (AC1, 515). As this respondent stated, one way for the health authorities to establish positive working relationships with the Aboriginal community is to respect and honor the culture and the diversity of the culture and not say that it has to fit into a “box” (AC1, 98). In other words approaching Aboriginal health issues need to be flexible.

An example used by this respondent was the use of oral reporting versus written reporting. She states that if the relationship with the Aboriginal community is strong and trusting then formal report writing is not seen as important as person-to-person reporting. She highlighted that it is very important to “catch up” (AC1, 575) and have a conversation than to just focus on the business aspect of the reporting. The written report can still be submitted but it’s more important to have that personal human contact. “I don’t mean to say that it isn’t in other communities [relationship building] but there’s just something really distinct about it in this community” (AC1, 657).

In terms of a cultural aspect of best practices there was also an emphasis on utilizing Elders or other members of the Aboriginal community. This type of approach was identified as one way to make health programs for Aboriginal clients truly holistic in nature where programs not only take into account the physical aspect of health but also one that addresses the mind, body, spirit and emotions.

One example is the use of Elders for opening meetings with a traditional prayer. In order to do this and be respectful to the Aboriginal community some “research” would have to be done to find out the traditional protocols and expectations of the Elder conducting the prayer. This was highlighted very strongly by one of the Aboriginal community respondents. She stated that it is important “to do your homework and find out who’s opening the meeting and then find out through direct conversation with them, what their personal practices are when it comes to spirituality” (AC1, 152).

Elders and other cultural persons were found to be important for bridging that gap between the Aboriginal community and the health program, both within the Aboriginal community health programs and the regional health authority. The use of lay people from the Aboriginal community working within a health program was seen as a best practice by one of the Aboriginal community respondents. She stated that this type of arrangement allows this person to bring that knowledge of culture to the health program. She said “we always rely on the community members to kind of guide, or influence the non-native workers” (AC2, 389). This allows for the non-Aboriginal health care staff to gain a better understanding of the history and the culture of the Aboriginal population that they serve.

Elders bring not only their cultural understanding of traditional spiritual practices and traditional use of medicines but also their expertise in terms of guidance and advice. Utilizing Elders in this capacity was also seen as a best practice that supports holistic health care for Aboriginal people. As one health authority respondent stated they are in the process of developing their cultural component to their program. This includes plans for including Elders on the clinical team but also using them in the design of the cultural program.

This health authority wants to have “elders more involved right on sight within the clinic, looking at ceremonies [and] being able to be accessed” by clients (RHA3, 182). In order to do this they are building relationships with various Elders from the surrounding community to make sure cultural protocols are in place. She emphasized that this process is very important to even to be called holistic health (RHA3, 202).

The final category under the question what do you think best practice means in the broader Aboriginal community goes back to the western definition of best practice. It was recognized that the Aboriginal community would define best practices similar to what it means in the western health care sense. For one health

authority this means taking a model or a program that could be seen as a best practice and having it adopted by the Aboriginal community. This model would be considered a best practice in the clinical sense where it would be recognized by the health care system as being a successful model (RHA1, 294).

As mentioned previously one health authority felt very strongly that the Aboriginal community would recognize best practices much the way she sees it, from the western scientific perspective. She stated that the Aboriginal community uses the term quite often (RHA2, 623) with her and they seem to be very clear that they mean it to be the best way to manage a patient (RHA2, 602), or to seek out experts, or conduct literature searches (RHA2, 651).

The use of specialized service was the way one Aboriginal community respondent described how the Aboriginal community may define best practices. She acknowledged that the term best practices may not be well understood by the Aboriginal community in its clinical sense but that they would understand health services that are considered specialized. She pointed out that she uses the phrase “specialize in wound care” (AC2, 311) to describe clinical care for people with diabetes foot ulcers. She appreciates that members of the Aboriginal community want to see improvements in their health and that they recognize the need for good clinical care to make this happen.

This view is also similar to one of the other Aboriginal community respondents. This particular respondent pointed out that some members of the Aboriginal community see best practices not as anything formal as health professionals do but from a perspective of “better services” on or off reserve (AC3, 184). In this it is acknowledged that such services (on or off reserve) are clinical in nature. Health care services are clinical western based services whether they are on the reserve or in the next health authority.

#### **Question 4: What do you think best practice means in the broader health care system?**

The participants were asked to give their thoughts on what they think best practices means to the broader health care system. All the respondents stated that they think the health care system views best practices primarily from a clinical western scientific perspective.

I categorized the responses into five themes. The first three themes are interrelated and speak to a definition similar to the formal definition of best practices as seen in the literature. But some responses included a theme that was outside the western scientific realm of best practices and were more in line with the Aboriginal community realm.

The five themes are as follows:

1. Evidence-based research.
2. Statistics: changes in health status or disparities.
3. Clinical practice standards: accepted and used elsewhere.
4. Community engagement and relationship building.
5. Other.

The themes from the responses to the question of what they think best practices means in the broader health care system mirrored the themes that had developed when they were first asked to define best practices from their own perspective. Five of the six respondents indicated that they believed that the health authorities view best practices as something that is grounded in evidence-based research. One Aboriginal respondent put it succinctly when she stated “best practices evolve around research” (AC2, 259).

The second theme responses support the first answer. All the respondents indicated that they think the health authority sees best practices as evidence of some sort that would show changes in health status or a change in health disparities. Usually this was described as statistics or something what would show “numbers attached to it” (RHA1, 372).

The third theme describes how the respondents believed that the health authorities would view best practices as supporting and maintaining the highest level of clinical practice standards. One health authority respondent stated that it was important for her health authority to use best practice to set standards within the departments, especially where chronic disease and diabetes management was concerned (RHA1, 361). An example of such clinical standards discussed is the use of the Canadian Diabetes Association’ (CDA) Clinical Practice Guidelines. As one Aboriginal community respondent put it the CDA guidelines are something that they follow as they are “nationally recognized” (AC3, 291).

While the clinical perspective of best practices was highlighted as something the health authorities would adhere to there was also the perception that they would support the notion of community engagement and relationship building. This was a concept that was discussed by the respondents throughout.

Three of the five respondents indicated that engaging the community and having them be involved in the addressing Aboriginal health issues was something that the health authorities would support as a best practice. In order for this to take place relationship building needs to occur between the Aboriginal community and the health authorities.

Community involvement and engagement was a very important process for one regional health authority when developing their Aboriginal health program (RHA3, 115). Building relationships was seen as important for the health authorities as suggested by two of the Aboriginal respondents. Each had indicated

that they both have a working relationship with their respective health authorities and that the region seems to appreciate this.

The last theme, other, in this section was based on one respondent's belief that the health authorities see best practices in a political light. She stated that she thinks that statistics and reported changes to health can be manipulated to suit the needs of the health authority. She believes that there can be a political base to determining what a best practice is. This could be based on the leadership of the health authority or even personally based and not necessarily organizational based. The way she put it is that "best practice is very personally defined through health authorities [and that] the squeaky wheel gets the grease" (AC1, 808). In other words, there may be more emphasis on a certain health issue or on a particular community based on where the discussion is coming from and how the health authority responds. She states "everything can be political...especially if you're talking health care" (AC1, 721).

**Question 5 and 6: Do you think there is a difference in the perceptions of best practices between the Aboriginal community and the health care system? If you believe there is a difference in the meaning of best practices between the Aboriginal community and the health authorities do you think it creates problems?**

These questions were asked in order to follow up on the first ones. I wanted to find out if each participant thought there were differences in the perceptions of the term best practices between the Aboriginal community and the health care system and if so does it create problems.

Three of the respondents made clear definitive declarations of either a yes or a no in response to whether or not there was a difference in perceptions to the definition of best practices. They then followed it up with answers that were congruent to the first question. For instance, one regional health authority stated clearly that she thought that there were no differences in the perceptions, so therefore did not believe it created problems.

At the same time two Aboriginal community respondents stated that yes they did believe there were differences in the perceptions and that these differences created problems. One stated flatly that there are problems because of these differences. She believes the health authorities do not understand the Aboriginal community, especially as it pertains to the concept of time. To her, relationship building is the key to any successful partnership between the Aboriginal community and the health authorities and she believes that this is not done as much as it should be. She says it takes time to develop programs and services with the Aboriginal community and that this process does not happen immediately. She stated "you can't come in and do a project in a month when it might take six months in the Aboriginal community" (AC1, 939).

The other Aboriginal community respondent who said there were differences stated that problems are created because there is a “gap in knowledge” about First Nations history (AC2, 466). She stated that there are a lot of historical influences on the health of First Nations peoples and that non-First Nations people in health care who do not understand this. She cited social assistance programs and the residential school system as examples of such historical influences that affect the health of Aboriginal people (AC2, 430).

This respondent wondered “without knowing some of the struggles this [Aboriginal] person has faced with their diabetes...how can you say you’re providing best practices when you have this gap of knowledge?” (AC2, 454). She questioned whether or not health authorities could really be providing best practices in terms of health care to Aboriginal clients if they “don’t know their history” (AC2, 438). She also said that if this is the case then the health services they are providing “may be lacking in terms of their ability to approach that with a better positive outcome, whatever the health issue” (AC2, 446).

But what is significant about the responses to these questions from the remaining participants is that their responses are incongruent in their answers. One health authority respondent said yes that there is a difference in the perceptions of the definition of best practices but then said no that she does not think it would create problems. But her response to the second question clearly implies that there could be problems based on a misinterpretation of language and terminology. She states:

I don’t think it really creates problems. I think it's more in the terminology of the language that's being used. In understanding the concept of what a best practice is, and understanding whether or not they're even using a best practice. Some terms are imposed [on First Nations communities] (RHA1, 435).

She said that if there were problems created by the differences in perceptions it would be “in understanding the concept of what a best practice is and understanding whether or not they're even using a best practice” (RHA1, 484). She says that there may be issues over language and the terminology being used to define best practices.

This respondent says that terms are imposed in the First Nations communities and that they adopt these for whatever project they are working on. Pilot projects and models are something that may be familiar to the Aboriginal communities in terms of health programs because these are terms that are currently being used. She says best practice is a term that will eventually be familiar to the Aboriginal community and they will soon be able to identify with it. In other words, if there is work being done with the Aboriginal community there could be problems if there is a lack of understanding of the basis for the terms defining the project.

The last health authority respondent stated that she believes there are both differences and similarities in the perceptions of the term best practices. She said both groups would want to see better health outcomes for Aboriginal clients but “I think there will be both differences and similarities. The Aboriginal communities will bring in more stuff like looking at historical things [and] the impacts on health” but that “from a general system, it’s not always going to take that into consideration” (RHA3, 388).

She said that there is a potential for problems if both parties are not clear on the health issue or concern. She stressed that if this clarity is not done at the beginning of health care negotiations between the health authorities and the Aboriginal communities the outcome may not result in a recognized “best practice” (RHA3, 477). She states that if this process continues and is not corrected it could actually “stop a program” (RHA3, 507).

In other words, any negotiations for a new program or service for the Aboriginal community may not be able to move forward due to the misunderstanding of the language behind best practices. They may not be able to find a mutual understanding to establish a common basis for establishing the program.

The last participant to show some incongruence in their answers was from the Aboriginal community. She stated no that she does not think there are differences in the perceptions of best practices between the two but prefaces it by saying that she believes that there are differences in the approach used to address Aboriginal health. She said “I think the end result is best practice but how you’re going to get there. If you’re going to get there successfully...it all boils down to approach or how you begin to get there” (AC3, 441).

So in one sense this respondent says no there are no differences in the perceptions of best practices implying that there would be no problems. But when posed with the question of whether she thinks there could be problems she responded by saying that maybe there could be based on the difference in approaches used to address Aboriginal health.

**Question 7:**

**If you believe there is a difference in the meaning of best practices between the Aboriginal community and the health authorities and that it is creating problems what do you think should be done to make things better?**

The next question I wanted to know was if you believe there is a difference in the meaning of best practices between the Aboriginal community and the health authorities and that it is creating problems what do you think should be done to make things better?

Five of the six respondents made recommendations. The one health authority who stated that there were no perceived differences and therefore no problems did not respond to this question. The recommendations were categorized into six sections:

1. Community engagement
2. Addressing gaps in knowledge
3. Relationship building
4. Flexible programs and services
5. Political support
6. Maintaining clinical standards

One of the most important recommendations made by the participants was the idea that when addressing Aboriginal health there needs to be community engagement and acceptance. All five of the respondents indicated a need to ensure that health programs and services have Aboriginal community involvement. Engaging the community in identifying needs and addressing health issues was seen as extremely important. One health authority respondent stated that it is important for the Aboriginal community to know their “needs are being heard” (RHA3, 286) and that by using this process it allows “the atmosphere to be open” (RHA3, 519).

One of the Aboriginal community respondents stated that involving the Aboriginal community in health care programming supports “community capacity building” (AC1, 1098). This type of approach in turn leads to relationship building and trust. As one Aboriginal community respondent put it, “it’s all about partners” (AC2, 622).

This leads us to the next recommendation, developing relationships. Again, all five respondents indicated that that in order to effectively address Aboriginal health issues there needs to not only be Aboriginal community involvement but real relationships between the Aboriginal community and health authorities as well. As one Aboriginal community respondent put it relationship building is “the fundamental piece” (AC1, 1102).

In order for this to happen there needs to be an appreciation that developing such relationships take time. One health authority respondent stated that her health authority sometimes thinks that “you can just go in and incorporate [programs]” (RHA1, 655) without considering that the relationships that she has established with the Aboriginal community has evolved over time.

One regional health authority respondent stated that community engagement and relationship building is the key to success as it creates an atmosphere of respect and trust. She says it is this basis that her program uses “to create anything [new] that we’re starting...for the Aboriginal health program” (RHA3, 492).

One Aboriginal community respondent stated it’s all about partners (AC2, 622). She says that she would recommend working with the health authorities as well as

the neighboring Aboriginal communities to help each other out (AC2, 619). Another says they used the relationship they had with their local regional health authority to adapt a program “to fit in our community” (RHA3, 135).

Another recommendation for this category of relationship building is to develop Aboriginal liaison positions to work in the local regional health authorities. One Aboriginal community respondent also suggested that Aboriginal representation also be on the regional health authority’s board of directors (AC1, 1145).

The role of an Aboriginal liaison within the health care system would be to act as that link to the Aboriginal community (AC3, 483). According to one Aboriginal community respondent liaisons from the Aboriginal community could assist the regions in developing programs designed for Aboriginal people. They could also be used to provide guidance and support to the staff of the health authorities when it comes to addressing Aboriginal health issues from a historical and cultural perspective (AC3, 489).

Another Aboriginal community respondent suggested that Aboriginal community liaisons would be able to open up a dialogue with individual clients with diabetes. This would help get them into the diabetes clinics sooner (AC2, 655). This respondent also stated that once this type of program becomes established the natural course of events would be to begin hiring Aboriginal health professionals to run the programs.

The respondents suggested that Aboriginal liaison positions would be very beneficial to the regional health authorities. Not only will they assist in identifying and supporting the needs of the Aboriginal community and establishing positive relationships but they will also enhance the reputation of the health authorities (AC2, 672). Adopting effective Aboriginal liaison positions would help establish trust towards the health authorities. Then the reputation of the Aboriginal staff and the health authority will grow within the Aboriginal community (AC2, 677) in a very positive way.

One health authority respondent stated that her region could use more liaison positions to assist with supporting their strategic plan of addressing Aboriginal health. She states that she is on several regional committees and recognizes that more Aboriginal representation is needed to support the regions Aboriginal health plan. This respondent also stated that the region’s intention is to become the employer of choice for Aboriginal people in their area and in order to make this happen they would need another Aboriginal lead, especially in human resources helping to develop a recruitment strategy (RHA1, 812).

The next recommendation for this category is to address the gap in knowledge on Aboriginal health issues. I put this under the category of establishing a process for knowledge transfer. This means that approaches used by the health authorities to address Aboriginal health issues need to include knowledge of Aboriginal culture,

an understanding of Aboriginal holistic health care, and an acknowledgment that there are historical and other influences on the health of Aboriginal people such as the social determinants of health.

In terms of culture there was a unifying acceptance that culture is an integral part of what influences the health of Aboriginal people. As one respondent stated “you need to know the culture, and [that] culture has an impact on diabetes” (AC2, 247). In other words, it is important to the health and well being of Aboriginal people for the health care system to understand, appreciate and accept the role of culture. This respondent stated that traditional health and healing is acknowledged by her as much as “the hard sciences” are (AC2, 158).

The significance of recognizing culture as being important to the health of Aboriginal people also acknowledges the uniqueness of the Aboriginal community in general. From this recognition comes the acknowledgement that the Aboriginal community, as a collective, has: a distinct history, has its own cultural processes to addressing health issues, has a holistic worldview, and addresses health issues from a broader interrelated perspective. Although this type of summary can be deemed general and pan-Aboriginal, painting all Aboriginal communities with the same brush, it has its merits in terms of recognizing the unique challenges facing Aboriginal health issues.

Although it is important to recognize Aboriginal communities as being diverse in and of themselves, there are common issues expressed by the respondents as being important for health authorities to acknowledge. There was a general emphasis on the need for respecting and honoring cultural processes used by the Aboriginal community. This took on many forms from respecting the role and knowledge of Elders (RHA3, 538) to accepting that traditional health and healing can influence health outcomes (AC2, 144) to offering gifts as a traditional form of gratitude (RHA1, 718).

It was important for many of the respondents to ensure that the health care system adopted some form of training to educate their employees on the significance of Aboriginal cultural knowledge. One Aboriginal health respondent stated emphatically “I don’t believe they (health authorities) really have knowledge of a lot of the First Nation’s histories or issues that affect their health” (AC2, 412).

Cultural awareness and or cultural safety programs have been suggested as one way to address the issue. For one regional health authority respondent it is important for them to provide culturally appropriate services (RHA1, 848). She stated that her region is developing a broad strategy to address Aboriginal health and she knows that this is a significant undertaking. To her it is important for her health authority to strongly enforce Aboriginal awareness training as “we’re not reaching the percentage of the population that we need to” (RHA1, 733). Another health authority participant responded by stating that it is “a lot of work to have

everyone understand somewhat of what the Aboriginal population is like” (RHA3, 616) and stressed the importance of cultural competency programs.

Adding cultural approaches to addressing Aboriginal health was seen by the respondents as making the health care system more holistic in nature. The use of cultural ceremonies and traditional protocol to open meetings (AC1, 151), or using Elders to guide program development (RHA3, 538), or acknowledging that clients with diabetes are attending traditional ceremonies (AC2, 252) are examples of holistic programming.

By virtue of addressing Aboriginal health from a holistic perspective and acknowledging the influences culture has on health leads into the discussion of looking at the social determinants to health. It was stressed by many respondents that it is important to look at Aboriginal health issues from a broad perspective. As one health authority respondent put it “seeing a person as...a whole person, with all the impacts that could be surrounding them” (RHA3, 312) is an example of addressing the social determinants of health.

The role of history and culture was seen as important components to properly assessing the health of Aboriginal people. This gap in knowledge of Aboriginal history by those who work in the health care system was identified as one of the problems by the respondents. One stated that while the health authorities are attempting to educate Aboriginal clients on their diabetes management the clients are “worried about getting the kids off to school, getting their lights paid for” (AC3, 320). She stated that some people in the health authorities “don’t understand what the native people are going through” (AC3, 316) saying that it is a lack of understanding of the social determinants of health.

One Aboriginal community respondent stressed that it is important for the health authorities to acknowledge the significance of the social determinants of health facing Aboriginal people. She said that of the recognized determinants of health there are “four or five” that the Royal Commission on Aboriginal People have stated had “the most application here on the First Nations people” (RHA2, 96). This respondent stressed that it is important for the health care system to acknowledge that “historical events have influenced the health of First Nations people” (RHA2, 430). She cited the reserve system, residential schools and the welfare system as examples.

The message here is for the health authorities to build this knowledge into the health care system. In order for this to happen it is recommended that there be more flexibility in its programming (AC1, 284) and approaches to Aboriginal health within the regions. There was overwhelming support for the idea that the health care system needs to recognize that the Aboriginal community must make their own decisions over their own health programs.

The healthcare system also needs to be flexible in its approaches to relationship building with the Aboriginal community. This means more time and an appreciation for cultural protocols and different ways of doing business. Resources must also be accompanied by Aboriginal health programming and used in different ways to suit the community. Examples given were to provide honorarium for volunteers and offering gifts to Elders (RHA1, 703).

Another recommendation that was seen in four of the six respondents was the support for maintaining clinical standards. This included the recognition of the Canadian Diabetes Association, Clinical Practice Guidelines along with the clinical standards set by the regional health authorities and Health Canada (AC2, 143). Another component to recognizing certain standards is acknowledging that the Aboriginal community may be working with models or frameworks that they may have adopted from elsewhere. Using legitimate tools such as program models that are utilized elsewhere and are accepted by the general health care system is another way of maintaining standards of care (RHA1, 436). The use of statistics to justify program success is another example of ensuring a good standard of care (RHA3, 345).

The last recommendation made by the respondents is the category of developing political support. Four of the five respondents suggested very strongly that there needs to be some sort of political support from the health authorities when addressing Aboriginal health. This can take the form of partnerships with the Aboriginal community (AC2, 621; AC3, 202; RHA3, 526)) to formally established memorandum of understandings between the two groups (AC2, 137) to establishing an Aboriginal community member on the health authority board of governors (RHA1, 1102).

One of the strongest ways to ensure political support for Aboriginal health programming was the recommendation to prioritize Aboriginal health as a mandated item in the strategic planning within the health authorities (AC1, 1152; RHA1, 738). Each of the respondents indicated that their health authority or community has established working relationships with each other. The three health authorities have established Aboriginal health as something built in to long range planning of the health authority. The Aboriginal communities have long standing relationships with their local health authorities.

One of the main recommendations was for the regional health authorities to have department heads become more involved in committee work with the Aboriginal community. This is especially true when planning programs and services. Aboriginal liaison positions have been noted earlier as enhancing the health authorities when addressing Aboriginal health. But what is recommended is to have decision makers from the health authorities be more involved in Aboriginal health program development. As one health authority put it there needs to be someone who can make decisions based on their authority and expertise. This type of decision would lie outside the role of the Aboriginal Liaison position. She

stated “expertise is wise decision making when you know that there’s going to be something that I don’t have the power and the authority to make” (RHA1, 550).

### **Scenario 1.**

#### **Part 1.**

Your organization is planning a diabetes health promotion project for a one week period. The local Aboriginal community is asking to be included in the project.

Please answer the following questions based on this scenario:

#### **Do you believe the following listed elements are essential to an appropriate diabetes health promotion campaign?**

Health Fair

Diabetes Walk

Presentations by health care personnel

Other physical activities

Blood sugar testing

Children focused activities

All the respondents answered yes to this question. Each believed that the elements listed are appropriate for a diabetes health promotion campaign. As one Aboriginal community respondent stated “it’s all about promoting health” (AC2, 704).

Some respondents indicated that they are using many of the elements listed in their diabetes programs. One Aboriginal community stated that “we’ve tried to incorporate a lot of the elements into our program” (AC2, 747). One said they were currently doing a health fair at the high school in her community. She stated that it is important to “bring diabetes programs to the community” (AC3, 558) as this is a safe environment.

One of the health authority respondents stated that their health authority has utilized many of the elements before and said that they work well because it “engages the community” (RHA3, 669). Another liked the fact that it is “holistic” (RHA2, 1062) and provides information in a number of different ways.

When asked if there was anything missing from these elements four of the respondents stated yes and two said no. Of the four that said yes, the main concern was the lack of Aboriginal community involvement. One stated that it is missing the Aboriginal population perspective and that it is important to understand that “communities want their own [programs]” (RHA1, 918). Another also pointed out that it would also need to be community specific as each Aboriginal community is unique and has a “different perspective and different culture” (RHA2, 1159).

Related to community was the recognition that culture was also missing in the list. One indicated that it is important to have Elder involvement in this type of event as the Aboriginal community has “respect for Elder involvement” (RHA1, 966) when it comes to addressing Aboriginal health issues. Others indicated that it is also important to highlight the need for proper food and nutrition (RHA2, 1137; AC1, 1370), including traditional foods (AC2, 770).

In terms of the clinical components to the list of elements one Aboriginal community respondent stated that her program is focused on health promotion. This means that she would not include blood sugar testing as part of her health fair. She stated that clinical testing would be out of her jurisdiction and that they would not want to do things they are not qualified to do.

### **Scenario 1.**

#### **Part 2.**

**The local Aboriginal community has asked that the following elements be included in the diabetes health promotion project.**

Nature walk

Traditional herbs and berry picking with Elders

Elders’ teachings on wellness and spirituality

Traditional ceremonies that could include opening pipe ceremony, sweat lodge, traditional sweet-grass ceremonies

Traditional dance (powwow, jigging), drumming and singing lessons

Traditional feast

Traditional activities for the children

#### **What do you think of these newly added elements?**

All six of the respondents agreed that all of the newly added elements of the health fair were appropriate for what the Aboriginal community has requested. Community involvement and culture were considered very important to most of the respondents. One health authority respondent stated that adding traditional components to the health fair is “definitely important to the capacity we can do it all” (RHA3, 726). She liked the added elements but stressed the need to have appropriate resources to support them.

One Aboriginal community respondent supported the new elements stating that they addressed what she believed was missing from the first set of elements listed. But she also pointed out that in order to be realistic about initiating some of the new elements that there needs to be an acknowledgement that it is going to take time. She says that the Aboriginal community and the health authority see time “in very different ways” (RHA1, 1008). What can take two to three hours to plan at a committee meeting will take a long time to initiate in the Aboriginal community. She said that this is why the Aboriginal community likes to do things their own way because they can develop something that is “acceptable to us in our own cultural way” (RHA1, 1041).

Some of the respondents stated that many of the new elements are already in place in their respective communities. Nature walks, using Elders, the sharing circles, and encouraging more use of traditional foods like dried meat and berries were a few examples provided. As one Aboriginal community respondent put it, she sees culture as “one of the main determinants for First Nations people. “[So] we’re trying to incorporate that into some strategy” (AC2, 610).

Out of the six only one said there were elements missing. This health authority respondent stated that you could also add information on traditional hunting and fishing to add to the importance of traditional foods. She stressed the need for the Elders to do a lot of traditional teachings on their knowledge of the body and for the health professionals to be a part of the sharing circles with the community members. This would help build relationships (RHA2, 1306) as it might make the community members more comfortable to see a health professional in this type of setting.

## **Scenario 2**

Your organization believes that some Aboriginal clients are taking herbal teas from traditional Healers in the Aboriginal community to treat their diabetes as well as taking medicine from their physician. These individuals did not volunteer this type of information. You think the clients are reluctant to discuss the use of traditional treatments.

### **How important is it to determine if clients are using herbal teas?**

Two of the Aboriginal community and one health authority respondents said that it is not important for them to find out if clients are taking herbal teas. One stated “it’s no big deal if it’s not going to affect their insulin or treatment” (RHA1, 1103) while another one said “it’s personal” (AC1, 1537) saying that such information is cultural and is not revealed that easily. One stated that they have seen positive results from the use of herbal teas on clients with diabetes (AC2, 656).

One health authority respondent stated that health care people “don’t know too much about our practices...so don’t get too upset about it” (RHA1, 1128). She also said that her region has respect for Aboriginal culture and acknowledges that this is part of the Aboriginal community.

This respondent also emphasized the importance relationships play when it comes to disclosing such information. She said if there is an established relationship with the communities then clients may tell the health care staff they are taking herbal teas. It makes it more difficult if that relationship has not been established. She says that there are community health representatives that now the community well and that clients may reveal this type of information to them (RHA1, 1112).

Another Aboriginal community respondent said that her staff is aware of clients who take both herbal and western medications to treat their diabetes. She said that they do not condone this but they also do not discourage it. She said the choice really lies with the client. If it is their wish to disclose such information then the nursing staff will address it, if they do not then “that’s their right as well” (AC2, 665). If they find out someone is using herbal teas but did not disclose the information then they would monitor their blood sugar.

These respondents were asked what they would do if they did find out by a third party if their clients were taking herbal teas, even though they acknowledged that it was not necessarily important for them. Each said that they would respect the client’s privacy and “take their cues from the client” (RHA1, 697). They would discuss it if the client wants to discuss it.

Two health authority and one Aboriginal community respondents said that it is important to find out if clients are taking herbal teas. The reason for such information from these respondents was to ensure that there were no clinical signs that the teas and the medications were affecting the client in a negative way.

One health authority respondent stated that she supports the use of clients using traditional teas for their diabetes treatment. She said that if she were to find someone who was using traditional teas that she would have them assessed clinically and stated “if in fact the client’s blood sugars are doing just fine, and they’re doing just fine [then] I don’t see any reason for interfering” (RHA2, 1423). From her perspective she said she would want to ensure that the western medicine being prescribed by the physician was not interfering with the traditional teas and said that “we [would] decrease our dose until they’re clinically stable” (RHA2, 1433).

On the other side, the other health authority respondent said that it is important to know if clients are taking herbal teas because she would want to know if it is affecting the client’s medication treatment. She said “there could be something that doesn’t jive with their western medicine” (RHA3, 785). But she said that this would be a learning opportunity to begin discussions between traditional Elders and the physicians within her health authority. It would be important for both to have knowledge of the herbal teas and western medicines in order to effectively provide treatment for Aboriginal clients.

The Aboriginal community respondent who said that it is important to know if clients are taking herbal teas stated “if that’s what’s going to get them through this then, then we will support it” (AC3, 805). She said they do not officially encourage it but do accept that this may be a route that a client wants to take to treat their diabetes. She said this information is asked at the very beginning as part of their overall health assessment interview.

These respondents were also asked what they would do if they did find out by a third party if their clients were taking herbal teas. One health authority respondent said that they would rely on the Aboriginal Liaison person to speak to them about it. She said if they find that there are no problems clinically then “I probably wouldn’t interfere” (RHA2, 1460). She said it is a “trust thing” (RHA2, 1451) and that it is important to not to take away peoples power of “informed choice” (RHA2, 1437) over their own health care. She said that the health care system should “never take away that independence, it should be enhancing it” (RHA2, 1525).

The other health authority said she would engage the use of Elders to get more information about the herbal teas. She strongly emphasize that clients have a right to confidentiality so they would not directly involve the client in the discussion unless it was directed by the client. In order to discuss this it would be “up to the client if they want to release [this] information or not” (RHA3, 820) even if the information came from a family member.

The Aboriginal community respondent said “I’d just ask” if she found out a client was using herbal teas. She said that this information comes out during their health assessments so she would continue discussing the matter with the client if they revealed they were using teas. In fact she said they have “never had a problem with it” (AC3, 799).

### **Scenario 3**

**Your organization has decided to make specific changes to encourage more members of the Aboriginal community to use its services. It wants to become more responsive to the needs of the Aboriginal community who have diabetes.**

#### **How important is it to make changes to your organization?**

Each respondent to this question emphatically said yes that it was very important to make changes to their respective organizations in order to encourage more members of the Aboriginal community to use its services. It was made quite clear that this is a direction needed in order to better meet the needs of the Aboriginal community.

Many respondents are already in the middle of making changes to their organizations to suit the needs of the Aboriginal community. The three health authorities have Aboriginal health departments where the focus is on addressing Aboriginal health issues. Some have diabetes programs built into health authorities’ strategic plans under such categories as Chronic Disease Management or Primary Care. Some health authorities have Aboriginal health as part of their long range visioning and business plans.

One health authority respondent said it is their goal to look at diabetes in the Aboriginal community and to find out why the Aboriginal community does not

access health services as much as it does (RHA3, 859). They are doing this through community engagement and getting the perspective of the Aboriginal community (RHA3, 909). They have done this through focus groups as well as conducting a literature search on Aboriginal health.

An Aboriginal community respondent said that they have already had a needs assessment done of their diabetes program and are looking at ways to address the issues identified in the report. She said it is clear that “programs have to change to meet the needs of the community” (AC2, 729). She said that they are aware that some of the Aboriginal community members with diabetes go for services elsewhere and they plan on addressing this. Another Aboriginal community respondent said they too try and identify the needs of their community. She said that they have a survey after each client visit that they can use to better their service.

### **What types of changes would need to be made to your organization?**

It was important for the respondents to find ways for the Aboriginal community members to utilize their services so that they can better meet their specific health needs. One health authority respondent said that through their strategic long range plan that they not only meet the diabetes health needs of the Aboriginal community but also become the “employer of choice” (RHA1, 1250) for them. It is hoped that with a stronger Aboriginal workforce in the health authority there will be a more positive view of the health services by the Aboriginal community. This type of process will require good relationship building by working with the Aboriginal community.

Another health authority hopes to develop better community support services to the Aboriginal community. This means bringing the services closer to the community through better outreach services or by having the location of clinics located at more accessible locations. This respondent stated “I highly believe in outreach and increasing that over time, in to different areas of the city or where the population is somewhat higher” (RHA3, 960).

Two Aboriginal community respondents indicated a need to focus on the youth. One said that her program is geared towards engaging youth in a discussion on diabetes prevention and looking at ways to break down the barriers (AC2, 1666). The other said that they are now looking at diabetes prevention and are going in to the schools in their community. She said “we’re trying to focus now on the younger people on prevention” (AC2, 775). They are focusing on nutrition and healthy lunch programs as one strategy.

This particular community is also trying to address health by looking at the social determinants to health. This would mean looking at educating their community leaders on the social determinants of health (AC2, 790). One of their strategies is to develop a better communications system between the departments within their community and focusing more on health promotion activities.

One health authority respondent recommended making changes that would help Aboriginal clients feel comfortable about using the services. She stated that there needs to be better ways to ensure specific Aboriginal groups have their needs met so that Aboriginal programs meet their unique needs as well. Aboriginal awareness training and a better understanding of Aboriginal culture would help in this process. She said something as small as “shaking hands” (RHA2, 1555) with Aboriginal clients would make them feel comfortable.

## Chapter 5: Analysis

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On the surface there appears to be a clear distinction between what best practices means to the health authorities and what it means to the Aboriginal community. However when looking at the responses from the participants under the context of knowledge of health and wellness and the validity of this knowledge it becomes apparent that this type of dichotomy is not so clear cut. There are no distinct separate camps that the participants belong to in terms of their connection to the Aboriginal community or the health authorities.

But what is evident is that the participants based the responses to the questions firmly under the context of western based science. There are two identified streams to the definition of what a best practice is – western science and Aboriginal community-based. But what emerges from this study is that when answering the question of what best practices means to the participants the answers were primarily scientifically themed in nature. Only when posed with questions that focused on the Aboriginal community did they respond with answers that reflected their thoughts and experiences in working in the area of Aboriginal health. There was a definite prioritized order to the responses – science based answers first followed by Aboriginal community-based themed answers second.

The significance of the responses being within the context of western science is the fact that four of the five respondents were Aboriginal. Two worked in the Aboriginal community and two worked in the health authorities. I originally anticipated that the categories that the responses would fall into would be based on the two areas of focus – health authority and Aboriginal community. I also thought that the participants who have Aboriginal backgrounds would provide answers primarily reflective of the Aboriginal community-based themes. This was not the case however.

The information that emerged from this study clearly showed that the respondents answered questions based on their professional backgrounds and responsibilities to their employers, not their personal backgrounds of being Aboriginal or non-Aboriginal. All are involved in providing support to health care services that affect the Aboriginal community. Of the participants who emphasized western-based responses to the definition of best practices four were trained registered nurses. The other is considered a health care para-professional whose job is to address Aboriginal health issues in a clinical health care setting. The answers to the questions within this study all came from the context of their professional training and current clinical responsibilities. Not from a perspective of Aboriginal versus health authority.

For example one of the non-Aboriginal health authority respondents put it this way: “I’m a nurse I see things different than...other people on the team...as a

nurse I would come back and I would want to know more, what are the clinical best practices?” (RHA1, 214). She stressed that when she took her training in nursing school “all I did was sciences” (RHA1, 671).

The second health authority respondent is an Aboriginal nurse. She based her responses with an understanding that she comes from the Aboriginal community and views her approaches to Aboriginal health care in this way. She promotes community engagement, the use of Elders and encourages the RHA to look at Aboriginal health from a holistic perspective.

But at the same time this respondent also acknowledges that she is using frameworks to address Aboriginal health that could be considered primarily western-based. She points out that Aboriginal health falls under the concept of Chronic Disease Management where diabetes care would fit. She also points out that the processes the RHA used to gather information on Aboriginal health involved focus groups, literatures searches and an environmental scan (RHA3, 914), all elements used in western health care settings.

This health authority respondent also stressed the important role on western medicine when answering questions regarding the use of tradition herbs by Aboriginal clients. Although this respondent supports traditional and cultural approaches to health within her health authority it did appear as though this type of approach would have to fit into the current western system.

When asked if it was important to find out if clients are using traditional herbal teas she responded by saying “I think it’s important in the sense of their health...because there could be something that doesn’t jive with their western medicine” (RHA3, 778). So in one sense this respondent advocates very strongly for the Aboriginal community to be involved in the process of addressing Aboriginal health. But then in another sense when posed with a specific situation that has clinical implications for Aboriginal clients it becomes clearer in her response where she would base her decision – in a clinical, western based framework. Traditional herbal teas would have to fit within the realm of western-based medicines.

The other health authority respondent acknowledges that her Aboriginal background is used to provide a link to the Aboriginal community on behalf of her health authority. But she clearly states that she is a representative of the health authority and brings that responsibility with her when meeting with the Aboriginal communities.

This respondent stated that her region is using a primary health care model that includes addressing Aboriginal health. Diabetes care would fit into this framework. She says that this is a relatively new model for her health authority. She says it is model “developed of how primary health care will be addressed. And, the model...has been developed in consultation with a cross section of

people within the RHA” (AC1, 220). This statement emphasizes how Aboriginal health will be fit into the existing structures of the western health care system that governs her health authority.

The two Aboriginal community respondents were also nurses who have very strong clinical backgrounds. The context of their responses also came from a western scientific framework despite working specifically with the Aboriginal community. In terms of clinical training one respondent stated “I’m from a nursing profession, a medical profession. I know what best practices is referring to” (AC2, 292). She pointed out that when she was in nursing school they learned “what has shown to influence health in a scientific [model]” (AC2, 127). This is what continues to guide her in her role as a nurse today.

This individual acknowledges that her western nursing is the primary method for providing health care, even to the Aboriginal community. It was not until many years later and further nursing training that she came to the realization that perhaps there were other factors that affected the health of Aboriginal people. She stated:

When I did my post RN degree...the [traditional Aboriginal] culture part of it was being...more recognized as...healing practices. And then now...I’m seeing more and more evidence of the culture affecting...health practices now for the health of native people (AC2, 141).

But despite the stronger acknowledgement of the role of Aboriginal culture and its influence on the health of Aboriginal people this respondent still speaks of best practices as coming from western clinical medicine. According to this participant their diabetes program offers services that meet high standards as identified by the health care community. She says that as far as best practices are concerned her program’s clinical team abides by the Canadian Diabetes Association’s Clinical Practice Guidelines. She says her nurses “do have those best practices that they...try and...meet...in their nursing care” (AC2, 207). They attempt to abide by these guidelines when providing care to their diabetes clients that come to their clinic.

She then points out that although she recognizes that best practices as outlined by the Canadian Diabetes Association are clinically valid she stresses that this in turn can cause problems in implementing them in the Aboriginal community. She stated that “these best practices that the CDA promote...they can’t meet those standards because...they’re [Aboriginal clients] struggling with...other everyday issues that their health is kind of put on the side” (AC2, 218).

So in a sense this respondent is having some difficulty with implementing the most current western-based best practices identified for treating diabetes. She states that although she recognizes the latest treatment for diabetes is valid based on the clinical research she believes that some of those clinical recommendations may not apply in the Aboriginal community. This is because she understands that

there are a multitude of other factors that the Aboriginal community is facing that are not addressed by the Canadian Diabetes Association's Clinical Practice Guidelines. Some of these are historical such as the impact on health from the residential school era (AC2, 431) and some are cultural such as community members with diabetes participating in traditional ceremonies (AC2, 245).

But in the end this respondent will still acknowledge that the services they provide are of high quality, but from the basis of western medicine. She stated when clients come to her clinic "I think they have the faith that we are treating them the best that we can [and that] maybe they would have more faith in our...health care services on the reserve if we did use the term best practices" (AC2, 337).

The other Aboriginal community nurse also emphasizes the significance of identifying best practices as being something rooted in western medicine. Although she states that she has worked with the Aboriginal community for many years and is Aboriginal herself she stated quite clearly "I don't practice the Indian way" (AC3, 848). Her emphasis on best practices was firmly based in western science. To her best practices is "quality assurance and research based [as] best practice evolves around research. And if you want to provide a top quality program, that's all based on the research" (AC3, 259).

This respondent emphasized the context of her program is truly a representation of what would be offered within the health authorities. She stated that her diabetes program is not only the health promotion end of disease prevention but also the clinical. To emphasize she stated that "you can give people their clinical tools such as blood [sugar testing] and medications teaching, and...meal planning, but there's also the preventative measures in terms of taking your medication at the right times" (AC3, 102).

In fact this respondent's support for western medicine is highlighted by the fact that her program is really "a sister program from the [regional health authority]. We just took a piece of it and brought it out here and delivered it out here" (AC3, 455). She did indicate that they make the program fit her community's needs and that they do try to incorporate some cultural aspect into their events and activities "based on recommendations from the community" (AC3, 757).

But it should be pointed out that even though the community recommends changes to their services based on needs it is still western-based lead. She stated that "we make recommendations [and] they tell us how to alter it. Then it'll meet both of our needs...the cultural aspect and the scientific western aspect" (AC3, 766).

This respondent also minimized the significance of traditional medicines such as the use of herbs and teas. She stated that they ask all their clients if they are using traditional forms of medicines when they come to her clinic. They support this

type of treatment but do not condone it either. “It’s not discouraged, but it’s not encouraged” (AC3, 819). In fact it appears as if traditional medicines are seen as something that is a last resort or something that will psychologically help an individual with an ailment. This respondent stated that for clients who use traditional herbs “that’s their belief and if mentally that’s what’s going to get them through this then, then we will...support it...we’ll never tell them not to” (AC3, 804).

### **Context of Knowledge**

This study suggests that best practices are rooted in western science and that mainstream health care practices are based on clinically proven research. But at the same time it has also been suggested that best practices have an Aboriginal perspective. This would include looking at best practices as something beyond what is accepted by the scientific community and looking instead at what is accepted by the Aboriginal community. By using this process it allows health issues to be addressed in ways that include a strong sense of community engagement and participation, and that looks at the social determinants of health, the role of culture, and the emphasis on such concepts as time and relationship building.

Best practices, as discussed above, is a term used primarily for the purposes of identifying health treatment approaches that are proven to be the most effective. What becomes recognized as a best practice is only recognized as such when it has been shown through rigorous scientific research. This process used to identify a best practice is the one that is accepted as the legitimate method by the scientific community, hence the western health care system.

Knowledge and the basis for identifying this knowledge becomes the focal point of this discussion. Best practices is knowledge that is steeped in western science. It originates from the evolution of the concept of evidence-based practices which have their roots in western medicine. Western medicine has its roots in western philosophy stemming from the age of the Renaissance. It was during this time period that saw the birth of the methods used in scientific inquiry that continues to be used in today’s western medicine.

But in order for one to accept that best practices is knowledge that is rooted in western science one has to agree that the basis for this is a western concept that is seen as legitimate and valid. In other words, knowledge that is accepted as being valid makes it supreme over all other knowledge, including Aboriginal knowledge of health and wellness. This gives the holders of this knowledge the power over its use and the control over the context of its use.

Hence, western institutions hold the power over scientific knowledge and controls its usage in the health care system. These institutions, whether they be universities or health authorities, have the power to accept or deny other forms of health and wellness treatments and approaches. They decide what will or will not be

acceptable to adopt into the mainstream health care system. In such cases all other forms of health care become known as alternative forms of treatment. They are an alternative to the mainstream, scientifically-based, health system.

Within this context, participants to this study have accepted the term of best practices as being western-based and by virtue of this they have in essence legitimized the origins and the basis for which it stems. By accepting this notion, one must place western science as the supreme knowledge over any other, including Aboriginal cultural knowledge.

Western philosophical thought has prevailed over all other streams of thought and this is reflected in the colonial and neo-colonial institutions present in Canadian society. These can be seen in our Canadian parliamentary system, our common laws and our governing institutions. The Indian Act and the treaty system are prime examples of such institutions that legally placed restrictions on Aboriginal knowledge throughout Canada's short history.

Cultural ceremonies were banned and restricted and practicing traditional medicines and other health and wellness practices became illegal under the Indian Act. The hereditary chief system was replaced by a replica of the parliamentary electoral system of choosing tribal leaders. This resulted in Aboriginal processes for addressing Aboriginal issues being suppressed and hidden from mainstream society.

Today, we are witness to the fact that western approaches to health for Aboriginal people have not been very successful. There is great disparity in health between the Aboriginal population and the rest of Canada. Only now are we experiencing a move towards accepting and addressing Aboriginal health issues that include cultural approaches to health and wellness.

But with the promise of better inclusion of Aboriginal cultural approaches to health and wellness one still has to recognize that one system is being placed into the context of another system. In other words, the Aboriginal community has to be able to fit their approaches to health and wellness into the current western-based health care system. Since western institutions hold the power over scientific knowledge and controls its usage within the health care system, Aboriginal health must find a way to fit.

Aboriginal knowledge on health and wellness may be legitimate and valid as recognized by the Aboriginal community but the Aboriginal community does not hold the power or the control to enforce this type of system into mainstream health care institutions. It does not hold any credence to the superiority of the western-based health system.

My research has shown that despite there being two streams of thought on what a best practice means – western-based and Aboriginal community-based, there still

is a hierarchy in terms of recognizing the knowledge behind each. The responses from my participants clearly showed that western medicine is seen as the true and valid knowledge on health care practices.

Even as each of the health authority respondents indicated that there is movement in each of their areas to be inclusive of Aboriginal health needs there still seemed to be a sense of apprehensiveness as to how this would work because they understand that it must fit the western health care system's current structure. They discussed very positive developments that would make it appear that the health authorities are moving towards recognizing Aboriginal health issues more seriously. But when pressed it seems that some respondents are uncertain if this will be as easily met as anticipated. There is a certain acknowledgement that Aboriginal health must fit into a system that may truly want to adopt Aboriginal approaches to wellness but face the realities of such factors as funding and human resources needed to make it happen.

Each of the health authorities has developed formal plans to address Aboriginal health issues and have placed Aboriginal diabetes into a variety of frameworks. These include adding Aboriginal health into the business plan of the health authority or placing it in to primary care or chronic disease management models. But despite these developments there are still some questions posed by the respondents as to how these will unfold.

One respondent stated that her health authority has developed a long range plan to address Aboriginal health but she wonders if they would be putting more financial resources into the area or whether or not there would be more human resources allotted as well. She stated that her health authority would support Aboriginal health care but then questioned its ability to enforce the plan when she said "we may not" (RHA1, 1210). This respondent put it clearly by stating "I really still believe that there's more to do in the Aboriginal community that can't be mapped by the RHA" (RHA1, 240). She worries that once the plan is implemented that it will be her that takes on the primary role of addressing Aboriginal health as part of her current job (RHA1, 240).

Another health authority is also making plans to address Aboriginal health. This respondent stated that her health authority also takes the issue seriously stating that "health care is a public service and there is an obligation to find ways to make changes for the Aboriginal community" (RHA2, 1540). She highlighted the "need to find ways to make it work for the Aboriginal community and how to find out what the problem is and suggestions to make it fit" (RHA2, 1550). But this respondent also pointed out that despite the movement towards addressing Aboriginal health within the health authority there is still a need to find funding, both "old and new" (RHA2, 1552). She understands the realities faced by the health care system when it attempts to address outside issues that need to be incorporated internally.

The findings from my research into the definition of best practices highlighted a number of issues. One is the context of the discussions with my participants. I posed questions pertaining to the concept of best practices. Since this is a term based in western science my participants responded within this framework. Despite interviewing individuals from the Aboriginal community and the health authorities there were no distinct lines drawn between Aboriginal versus health authority in the answers. What resulted instead was a definite priority to align the discussion to reflect a western-based philosophy. This process was the basis used to address Aboriginal health within the context of the broader western health care system.

## Chapter 6: Conclusions/Recommendations

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The focus of this study was not to explore the views from the participants that focused primarily on specific clinical treatments on diabetes care, such as those found in clinical trials or interventions. The focus was, instead, to explore the broader discussion of best practices as a concept. What does it mean to take the issue of Aboriginal diabetes and approach it from a best practice perspective from the point of view from those who work in the Aboriginal community and those who work in the health authorities?

Is the term best practices purely seen as a western concept embedded only in the realm of health care services? Or does it include traditional Aboriginal health care practices as well? And how does either party view it? In light of the fact that diabetes in the Aboriginal community is growing at an alarming rate it is becoming apparent that this health issue needs to be addressed in ways that are sensitive to the unique needs of the Aboriginal community.

I asked this at the beginning of this study because there is growing movement within the health care system to address Aboriginal health issues in a way that is more responsive to the unique cultural and geographical needs of the community. Therefore it is important to both the Aboriginal community and the health care system to be clear on the meaning of a successful program or service, hence, “best practices”. Having a better understanding of what constitutes a successful health program, service or treatment, and the processes used to define this as a best practice by each party will increase the chances for success when it comes to addressing Aboriginal health issues.

Clearer language and a better understanding of the definition of “best practices” between the Aboriginal community and the health authorities will allow the Aboriginal community to be better prepared when initiating discussions with the health authorities on Aboriginal health programming or services. At the same time, the health authorities will be able to better meet the unique needs of the Aboriginal community if there is a clearer sense of what it is they are being asked to provide. Each will need to know if what is being negotiated will be acceptable to their respective organizations in terms of programs and services and this process can become smoother once they have a better understanding and acceptance of the measurements of success that is acceptable to both parties.

The scientific discourse on Aboriginal health care best practices is lacking. There continues to be a stronger focus on what is considered scientifically or clinically proven health care practices. Best practices for the most part are considered scientifically sound and are accepted as a standard process within the realm of the health care system.

Examples of best practices significant to the Aboriginal community as found in this research include the following: accepting a best practice as something that is defined by the Aboriginal community; community engagement that includes addressing the social determinants of health; accepting Aboriginal community processes that include relationship building and different concepts of time; and the use of culture, Elders and looking at health from a holistic perspective.

In accepting this notion of an Aboriginal perspective of best practices there are policy implications to consider. These would assist the movement towards to addressing Aboriginal health issues by including best practices that would incorporate traditional holistic forms of health of health care practices.

### **Policy Recommendations**

The following are policy recommendations identified as a result of this research study:

#### **A. Defining a Common Language within the Terms of Reference:**

Each party involved in developing health care programming designed to address Aboriginal health must have a clear understanding of what a successful outcome would look like. It must be made clear at the beginning of any negotiations what constitutes a best practice or a successful program. It must also be made explicit from whose perspectives are these best practices being based on, the health authorities, the Aboriginal communities or both?

**Policy Recommendation:** Health care negotiations on Aboriginal health include a clear Terms of Reference with definitions acceptable to all parties.

#### **B. Develop Community Partnership Model(s):**

If it is acknowledged that there are best practices from an Aboriginal perspective that are different in nature than those identified by the health care system then it is important for the health authorities to use this as a basis to develop Aboriginal health programming. This would allow for the health authorities to not only recognize the unique health needs of the Aboriginal community but develop health services from a culturally, holistic perspective and would allow Aboriginal people to have a stronger say in the design and delivery of such programs.

But it also must be acknowledged that this can only be done through recognizing and accepting the unique processes needed by the Aboriginal community to develop partnerships and establishing relationships. This process takes time and must be workable within the health care system.

Health authorities need to establish high level administrative leads that would assist the health authorities in addressing Aboriginal health issues in an effective way. These roles or positions should have the authority and flexibility to develop partnership models to suit the unique needs of each Aboriginal community.

**Policy Recommendation:** Health authorities must establish high level administrative leads to address Aboriginal health concerns from a multilevel perspective with the intent on establishing formal relationships and developing community partnership models with the Aboriginal community.

**C. Teaching of Aboriginal history and the effects of colonialism on the health of Aboriginal people to all health care personnel:**

This research highlighted the significance of the need for the health care system to understand the history of Aboriginal people in Canada. Many examples were given by respondents who stated that they have witnessed health care workers not being able to fully relate or understand the concerns of their Aboriginal clients because they were unable to appreciate their histories or experiences. The impact of the residential school system and of how it continues to negatively impact Aboriginal people today is one example. Many respondents stated very strongly that health care workers cannot provide good quality health care if they do not understand or have knowledge of the histories of their clients.

**Policy Recommendation 1:** All health care schools and institutions must implement course content that pertains specifically to the teaching of the history of Aboriginal people in Canada and how this experience has had an impact on the health of Aboriginal people today. As part of this teaching would be a discussion on the Social Determinants of Health and its profound impact on the health of the Aboriginal population.

**Policy Recommendation 2:** Clinical Practice Guidelines that are provided to address health issues that affect the Aboriginal community must also implement a piece that addresses the historical impacts of the Aboriginal population. One example would be to have this included in the Canadian Diabetes' Clinical Practice Guidelines.

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## Appendix A: Guiding Interview Questions

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### Note:

As Ethnomethodology is “the study of everyday life, the routines and rules people use to go about their everyday business, the norms and values they employ to deal with and relate with other people” (Slattery, 2003, p. 104) the author wishes to gain an understanding of how health care managers or program coordinators from the health authorities and the Aboriginal community make sense of their Aboriginal health programming world.

Conversational analysis is a branch of ethnomethodology that “focuses on the detailed features of talk and their role in creating and sustaining a sense of social order” (Rothe, 2000, p. 49). The use of the interview is the main method used in collecting data in conversational analysis. The interview is considered “a social encounter in which knowledge is constructed” and not just a “pipeline for transmitting knowledge” (Holstein and Gubrium, p. 68 in Dowling, p. 829).

For this study the author is using conversational analysis through interviews to assess the underlying rules that govern the day-to-day activities of health program managers and diabetes coordinators in the area of Diabetes care. The first set of interview questions will be used to provide a glimpse of how these workers are able to make sense of their environment under normal everyday circumstances. The information obtained from the following guiding interview questions will hopefully reflect the structures, guidelines, boundaries and knowledge frameworks of which these individuals have to work within their organizations.]

The first two questions pertain to your present role within your organization.

1. What do you think best practices means?

Tags:

- a. What is your understanding of best practices?
- b. What do you mean?
- c. Can you give me examples?
- d. How do you come to that?
- e. Why is it important to you?

2. How do your diabetes programs fit your definition of best practices?

Tags:

- a. What do you mean?
- b. Can you give me examples?
- c. How do you come to that?
- d. Why is it important?

The next two questions are to gather perceptions in a broader sense.

3. What do you think best practice means within the broader Aboriginal community?

Tags:

- a. What is your understanding of how the Aboriginal community defines best practices?
  - b. What do you mean?
  - c. Can you give me examples?
  - d. How did you come to that?
  - e. Why is it important?
4. What do you think best practice means within the broader health care system?

Tags:

- a. What is your understanding of how the health authorities define best practices?
  - b. What do you mean?
  - c. Can you give me some examples?
  - d. How did you come to that?
  - e. Why is it important?
5. Do think there is a difference in the perceptions of “best practices” between the Aboriginal community and the health care system in general?
6. If you believe there is a difference in the meaning of best practices between the Aboriginal community and the health authorities do you think it creates problems?

Tags:

- a. What do you mean?
  - b. Can you give me examples?
  - c. How did you come to that?
  - d. Why is it important?
7. If you believe there is a difference in the meaning of best practices between the Aboriginal community and the health authorities and that it is creating problems what do you think should be done to make things better?

Tags:

- a. How should the problems be fixed?
- b. What do you mean?
- c. Can you give me examples?
- d. How did you come to that?
- e. Why is it important?

### **Sample Scenario and Guiding Interview Questions**

#### **Note:**

An Ethnomethodological viewpoint believes that social order is very sensitive and precarious. Any real or perceived challenge to this social order has the potential to create chaos and uneasiness to individuals experiencing this threat. Our everyday routines that help maintain our sense of social order are very important for us in order to function properly and make sense of our world. It is these routines that allow us to function as a social group at home, at work, or out in the community.

They are done at a subconscious level and are taken for granted as they are so ingrained in our being.

When faced with a challenge to our sense of order and routine the individual is expected to rely on this subconscious knowledge and use his or her abilities to bring back their own sense of order in order to create some understanding of the circumstances. For the ethnomethodologist, it is the study of the persons' behavior when experiencing these types of challenges that is important. This type of research attempts to gain an understanding of these everyday routines and the rules that govern peoples' behaviors, thoughts and actions (Dowling, 2005; Slattery, 2003).

For the second part of this study I wish to also explore how these individuals make sense of their world when faced with potential challenges to their sense of order. It is hoped that this will demonstrate how the informants define their normal working world when faced with new challenges. Scenarios, followed by more open-ended interview questions, will be used to get this information. By using different scenarios the writer hopes to ascertain how these individuals adapt to new challenges to their current working environment.

A total of three scenarios will be developed in order to probe reactions to real life examples of potential gaps and overlaps in important elements of diabetes treatment, prevention and promotion. They will be pretested and modified before inclusion in the data collection. The following is an example:]

A total of three scenarios will be developed in order to probe reactions to real life examples of gaps and overlaps in conceptions of important elements of diabetes treatment, prevention and promotion. They will be pretested and modified before inclusion in the data collection. The following is an example:

**Scenario #1.**

**Part #1.**

Your organization is planning a diabetes health promotion project for a one week period.

The local Aboriginal community is asking to be included in the project.

Please answer the following questions based on this scenario.

Do you believe the following listed elements are essential to an appropriate diabetes health promotion campaign?

Health Fair

Diabetes Walk

Presentations by health care personnel

Other physical activities

Blood sugar testing

Children focused activities

How do you come to this?

Why is this important?

Do you think there are elements that are missing?

What would those be?

How did you come to that?

Why are they important?

**Part #2.**

The local Aboriginal community has asked that the following elements be included in the diabetes health promotion project.

Nature walk

Traditional herbs and berry picking with Elders

Elders' teachings on wellness and spirituality

Traditional ceremonies that could include opening pipe ceremony, sweat lodge, traditional sweet-grass ceremonies

Traditional dance (powwow, jigging), drumming and singing lessons

Traditional feast

Traditional activities for the children

What do you think of these newly added elements?

How important would these be to your organization?

How do you come to this?

Why is this important?

Do you think there are elements that are missing?

What would those be?

How did you come to that?

Why are they important?

Do you think that there is something in the final list that should not be included?

Why?

How similar are the two lists?

**Scenario #2.**

Your organization believes that some Aboriginal clients are taking herbal teas from traditional Healers in the Aboriginal community to treat their diabetes as well as taking medicine from their physician. These individuals did not volunteer this type of information. You think the clients are reluctant to discuss the use of traditional treatments.

Please answer the following questions based on this scenario.

How important is it to determine if clients are using herbal teas?

Tags:

- a. How would you investigate this?
- b. What do you mean?
- c. Can you give me examples?
- d. How did you come to that?
- e. Why is it important?

How would you go about finding out if clients are taking herbal teas?

Tags:

- a. How would you investigate this?
- b. What do you mean?
- c. Can you give me examples?
- d. How did you come to that?
- e. Why is it important?

What would you do if you identified clients who admitted to using traditional herbal teas?

Tags:

- a. How should the situation be addressed?
- b. What do you mean?
- c. Can you give me examples?
- d. How did you come to that?
- e. Why is it important?

### **Scenario #3.**

Your organization has decided to make specific changes to encourage more members of the Aboriginal community to use its services. It wants to become more responsive to the needs of the Aboriginal community who have diabetes.

Please answer the following questions based on this scenario.

How important is it to make changes to your organization?

Tags:

- a. What do you mean?
- b. Can you give me examples?
- c. How did you come to that?
- d. Why is it important?

What types of changes would need to be made to your organization?

Tags:

- a. How would things change on a structural/staffing/environmental level?
- b. What do you mean?
- c. Can you give me examples?
- d. How did you come to that?
- e. Why is it important?

## Appendix B: Information Sheet

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### INFORMATION SHEET

(To be used for both Aboriginal community representatives and health authority representatives)

Best Practices: Does it mean the same thing in the Aboriginal community as it does in the Health Authorities when it comes to diabetes care?

Principal Investigator: Marty Landrie, MSc student, School of Public Health, University of Alberta  
Contact info: 780-994-8925

Co-Investigator: Dr. Lory Laing, PHD, Professor, School of Public Health, University of Alberta  
Contact info: 780-492-6211

#### Background:

The term “best practices” is a phrase that is used often in the health care system. I am interested in what this term means. I especially want to know what this term means to people who work in the regional health authorities and in the Aboriginal communities.

#### Purpose:

You are being asked to participate in a research study to compare the meaning of the term “best practices”. The purpose of this study is to compare what “best practices” means between people who work in the regional health authorities and in the Aboriginal communities.

#### Procedures:

You are being asked to be interviewed by the author for this study. This will last approximately one hour. The interview will be audio tape recorded and written up word-for-word by the author. Once this is done the author will interview you once again. This will be done to check for clarification and accuracy of the first interview. The second interview will also be audio tape recorded. It will last approximately one half hour. The interviews will be at a location of your choice. The setting must be one that will make sure no one can overhear the interview.

#### Possible Benefits:

This study may not have any direct benefits for you. However this research may provide useful information about the meaning behind the term “best practices”.

#### Possible Risks:

The final written text or published reports of this study will not identify you by name. Every effort will be made to not include direct quotes or paraphrases within the body of the text that will directly or indirectly identify you.

#### Confidentiality:

All audio tapes and written transcripts of the interview will be kept private and confidential and you will not be identified by name in any reported results.

Voluntary Participation:

You are free to withdraw from the interview at any time without having to give any explanation. You also do not have to answer any specific questions during the interview.

Contact Information:

Please contact the individual identified below if you have any questions or concerns:

Felicity Hey  
Graduate Programs Administrator  
School of Public Health, University of Alberta  
780-492-6407

## Appendix C: Consent Form

### CONSENT FORM

**Part 1 (to be completed by the Principal Investigator):**

Title of Project: "Best Practices": Does it mean the same thing in the Aboriginal community as it does in the Health Authorities when it comes to diabetes care?

Principal Investigator(s): Marty Landrie Phone Number(s): 780-994-8925

Co-Investigator(s): Dr. Lory Lang Phone Number(s): 780-492-6211

**Part 2 (to be completed by the research subject):**

Yes No

Do you understand that you have been asked to be in a research study?

Have you read and received a copy of the attached Information Sheet?

Do you understand the benefits and risks involved in taking part in this research study?

Have you had an opportunity to ask questions and discuss this study?

Do you understand that you are free to withdraw from the study at any time?

Has the issue of confidentiality been explained to you?

Do you consent to being audio taped?

Do you know what the information you say will be used for?

Do you give us permission to use the information you provide for the purposes specified?

Who explained this study to you? \_\_\_\_\_

I agree to take part in this study: YES  NO

Signature of Research Subject \_\_\_\_\_

(Printed Name) \_\_\_\_\_

Date: \_\_\_\_\_

Signature of Witness \_\_\_\_\_

I believe that the person signing this form understands what is involved in the study and voluntarily agrees to participate. Signature of Investigator or Designee \_\_\_\_\_

## Appendix D: List of Symbols

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### Informant Interview Codes

AC1 Aboriginal Community respondent #1  
AC2 Aboriginal Community respondent #2  
AC3 Aboriginal Community respondent #3  
RHA1 Regional Health Authority respondent #1  
RHA2 Regional Health Authority respondent #2  
RHA3 Regional Health Authority respondent #3

The corresponding number after the informant codes indicate the exact line number the quotation was taken from within the transcribed interview text.

Example:

AC1, 196 = Aboriginal Community respondent #1, line 196.